Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Quality care in community hands. Planning for the future.

2010-2011 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Table of Contents

Local Health Integration Networks.....2

Vision, Mandate, Mission and Values.....3

Message from the Board Chair.....4

The HNHB LHIN Board of Directors.....5

Message from the CEO.....8

Continued Evolution of the HNHB LHIN.....10

Snapshot of the HNHB LHIN.....12

Engaging our Communities.....15

Fostering Collaboration and Enhancing Quality.....21

Moving our Priorities Forward.....23

Performance Indicators 2010-11.....42

Financial Statements.....46

Notes to the Financial Statements.....54

Local Health Integration Networks

Right Care, Right Place, Right Time

With the Ontario launch of Local Health Integration Networks in 2005 a wave of change in health care began. No longer would our health care system be centrally managed. Today, 14 Local Health Integration Networks (LHINs) are responsible for planning, integrating and funding the health services for community support services, long-term care homes, community health centres, community care access centres, mental health and addictions services and hospitals.

The benefits of the LHIN model are many. Health care planning and decision-making are taking place close to home so that local needs can be identified and addressed. LHINs enable continuous and meaningful engagement with the communities they serve and the health service providers that deliver the care. They allow for flexible solutions to meet community needs.

The work of the LHINs is guided by an Integrated Health Service Plan (IHSP), a blueprint for health improvement priorities. The IHSP is refreshed every three years. The LHIN board and staff carry out the directions of this plan in concert with health service providers and community members.

Provincially, this past year brought greater focus to quality of care and accountability in health care with the introduction of the *Excellent Care for All Act (ECFAA)*, which came into law in June 2010. This Act puts Ontario patients first by strengthening the health care sector's organizational focus, and it's accountability for delivering high quality patient care. The goal of the legislation is to blend quality and value in such a way that Ontarians will be able to count on their health care system for generations to come.

Vision, Mandate, Mission and Values
Hamilton Niagara Haldimand Brant LHIN

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need to access local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real conversation

Message from the Board Chair: Juanita G. Gledhill

Creating a healthcare system that keeps people healthy, gets them good care when they are sick and will be there for our children and grandchildren – this is the LHIN's guiding vision. In June 2005, it was this vision which took me, my esteemed colleague and vice-chair Jack Brewer and our former colleague Kim Stasiak along with our founding CEO Pat Mandy from our local communities into the newly created Hamilton Niagara Haldimand Brant, including the city of Burlington and most of Norfolk County, Local Health Integration Network.

Aging at Home Announcement, Hamilton, August 2010

In the course of countless conversations, I have often reflected on the leap of faith we took in 2005 to send in our applications to be a part of bringing local community decision-making to Ontario's health care system. Reflecting on a six year journey that brought the LHIN model to life, I appreciate even more so how incredibly possible achieving this vision of a health care system is when communities and providers come together. This vision is possible when the focus is on the citizen as a whole person, not as a diagnosis; when we consider citizens and the important people surrounding them – their caregivers – in system planning; when we balance needs and wants with evidence and feasibility to ensure a higher level of quality care, consistently delivered in stable, well equipped safe environments.

Transformation is never easy nor is change. I have had the privilege of serving with dedicated board members who were prepared to fulfill our mandate of system integration and transformation. I would also like to acknowledge those dedicated members of the public who are so interested and passionate about health care in their community that they faithfully attended our board meetings to learn and offer their comments. To those individuals and groups who shared with us their personal experiences and that of their loved ones, and challenged us to make health care better for the future, I whole-heartedly thank you. To this day I reflect on those stories, especially as we deliberate and make decisions to improve local health care.

We have improved supports for the frail elderly, improved access to services for children, integrated care to link services across the system of care, and increased care in the community so in future, people will not live nor linger in hospitals because they have access to the care and support they need to live independently at home.

I sincerely thank our new CEO Donna Cripps who joined us this year and brought with her tremendous energy and vision to continue to transform the local health care system in collaboration with our staff and with our new board leadership and members.

I thank all of our staff, our providers and those very many citizens who engaged with us and with me personally during my tenure. Finally, I thank our board members for their support and outstanding service. It is has been an honour and a privilege to serve you and our community as Chair.

Juanita G. Gledhill

The HNHB LHIN Board of Directors

Juanita G. Gledhill, Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"Creating a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren is a shared responsibility. As I reflect on the journey that brought the LHIN model to life, I have full confidence that achieving this vision is entirely possible. Our communities are already experiencing the benefits of a health care system wherein the LHIN, health professionals, community partners, and the people who live and work here, work together toward this shared vision. We have made significant progress in creating a health care system we can be proud of – one that is responsive to local needs, provides equitable access to high quality care, is efficient, sustainable, and provides people with value for money."

Jack Brewer, Vice-Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"In June, my six year term as a member of the LHIN Board of Directors will come to an end. As one of the original members of the LHIN start up Board I have enjoyed working towards refinement of health care services designed specifically to serve the needs of people we talk to within the community. The task of planning and executing health care services from the grass roots has been a challenge. A great deal of duplication has been eliminated and services of all types integrated to ensure excellence in health care exist for our people. Many difficult and sometimes controversial decisions have been addressed to ensure our citizens receive the highest quality care at a cost which can be sustained and passed on to future generations."

"The LHIN has worked hard to establish and upgrade local preventative health services which result in fewer people needing hospital services. We have also attempted to strengthen services for people leaving hospital thereby avoiding a return visit. Top tier emergency rooms at Centre of Excellence hospitals will ensure high quality care is always provided to high risk seriously ill patients. Special focus on support services for elder citizens to remain among family and friends in the comfort of their own homes has been a major priority. We have expanded the health care services available for those experiencing mental illness and for the thousands of children within our LHIN boundaries."

"Change takes time and is seldom fully understood but is appreciated when a critical personal experience is encountered. The LHIN Board will have much to accomplish in the years ahead, and hopefully my involvement has helped make this an easier journey. Thank you for allowing me to serve."

Douglas Archibald, Member

Appointed: May 9, 2007 • Term: 2 years
Re-appointed: May 9, 2009 • Term: 3 years

"The past year has been particularly gratifying as I observe the Aging at Home initiatives maturing and gaining widespread acceptance by seniors in our LHIN who wish to remain at home. These initiatives have made it possible to realize the wishes of the seniors by providing accessibility to the many in-home support programs funded by our LHIN and supported by the many competent, caring and dedicated health care providers within the LHIN. I sincerely hope that the provision of these services and programs and the "stay at home" attitude adopted by our senior community is sustainable into the future."

Ruby Jacobs, Member

Appointed: March 3, 2010 • Term: 3 years

"Ontario LHINs continue to provide a clear and straightforward model for the delivery of quality health care in Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk. Accountability agreements between the provincial government and the HNHB LHIN and between the HNHB LHIN and the health service organizations direct the implementation of culturally appropriate and superior health programs and services for our communities. The HNHB LHIN remains focused on the accountability agreement deliverables that meet the health needs of local residents and families. Indicator data can now be analyzed and used to inform quality health care improvements, health service collaborations and efficiencies of time, efforts and materials leading to cost savings. Many successful initiatives have been implemented despite some challenges and I look forward to another productive year."

Bob Lawler, Member

Appointed: October 29, 2008 • Term: 3 years

"The last year has seen ongoing pressures in the health care system. We at the LHIN have worked with our partners - the providers - to address these pressures by reallocating resources to make the health care system as accessible and transparent as possible for the consumer. Our successes cannot be measured in major milestones but are incremental in nature as the system moves forward. I believe the LHIN has and is making a positive difference in the delivery of health care."

Bill McLean, Member

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years

"I am pleased that I had the opportunity to serve on the LHIN Board for the past five years. During that time I have met a myriad of health care providers, both staff and volunteers, who dedicate themselves to providing care to their fellow citizens. This dedication leaves me convinced that local decision-making, relative to the needs of our LHIN population, will be a very important tool in improving Ontario's health care system both for the present and for the future. I also would like to congratulate the LHIN staff for all their hard work and dedication."

Bill Millar, Member

Appointed: March 7, 2007 • Term: 2 years
Re-appointed: March 7, 2009 • Term: 3 years

"In addition to the many specific programs that have been initiated or enhanced through LHIN planning and funding over this past year, the HNHB LHIN has continued to build strong networks and relationships among its health service providers. It is these relationships that will be the key as we move towards a health care system whose components work together effectively and efficiently to provide better, more accessible and sustainable health care for all of our citizens."

Janice Mills, Member

Appointed: May 17, 2006 • Term: 13 months
Re-appointed: June 17, 2007 • Term: 3 years
Term Completed: June 16, 2010

"The completion of the Clinical Services Plan was a significant achievement, but more directly, the co-operation of our health care providers in the LHIN to produce the document shows that we can work together successfully."

Helen Mulligan, Member

Appointed: June 17, 2010 • Term: 3 years

"As our family was a recent user of the health care system, I became acutely aware of the advantage of centres of excellence. We were grateful to have skilled professionals with up-to-date equipment at hand for quick diagnosis and treatment. With new technology and new methods of treatment, hospital stays are shorter and wait times are improving. As a board member, it is a pleasure to meet health care providers and community members who are creating improved health care related programs. This year, I look forward to sharing ideas in governance to governance meetings as community based decisions are made to improve health care."

Michael Shea, Member

Appointed: October 28, 2010 • Term: 3 years

"The role of the LHIN is extremely important because the focus of care is based on local community needs - there is an understanding that different communities may require different types and different levels of service. As a parent and grandparent, the LHIN's vision is very important to me - keeping people healthy, getting them good care when they are sick, and being sustainable, so that future generations (our children and grandchildren) will be looked after. My fellow board members and the staff of the LHIN are a group of extremely dedicated and community-minded individuals who care about health care and want to make a difference. I am proud to be associated with them and look forward to the future."

Message from the CEO: Donna Cripps

Health care is something that's always been very close to my heart. It's my passion. I've always known that I wanted to work in health care in some capacity, and I have had the privilege of working in a variety of roles from clinical practice to leadership.

One thing that I hold dear, throughout my variety of experiences, is my unwavering commitment to putting patients first. After all, health care is about people. It's about you and me, our families, friends and neighbours. I am committed to working toward making people's health care experiences better and it is this commitment that guides me each day in my role as CEO of the Hamilton Niagara Haldimand Brant LHIN.

I have been in this role since October 18, 2010 and I am deeply proud of the work of this LHIN, our achievements and our future directions.

In my short time since joining the LHIN, I've had the privilege of getting to know many of the people who live and work in our communities. In November 2010, we held a series of 'CEO Meet and Greets' throughout our LHIN region where I had the opportunity to meet and speak one-on-one with many of our health service providers. This was an opportunity for me to foster new relationships and to re-connect with providers that I have come to know over the years. It is very important to me that providers get to know me, ask questions, and voice their opinions on the transformation and evolution of our local health care system.

CEO Meet and Greet, Fort Erie, November 2011

In addition, the LHIN created more opportunities for people to engage with us. We introduced the Delegations Policy, which allows people to share their views with our Board. On our website, I began my own blog, where I discuss how the LHIN is working to improve access to care and people are invited to join the discussion by posting their comments and questions. At a December 2010 Ontario Hospital Association (OHA) conference, I spoke about community engagement and how it is a fundamental and important part of the way LHINs work.

In late November, we held an *Aiming for Better Health* forum where health service providers, community and social service agencies, and residents came together to create and take action on a plan to improve chronic disease prevention and management in Fort Erie. This is an example of what can be accomplished with leadership, collaboration, and a strong desire for positive change.

LHIN staff and I met with representatives from our local MPP Constituency Offices in February 2011. This was a great opportunity to share with them some of the activities underway in our LHIN and to learn what health care issues our MPP offices have been hearing from their constituents.

At the provincial level, I am honoured to be part of a provincial working group tasked with finding ways to improve alternate level of care (ALC) issues, wait times, and system performance.

Throughout my career, I have learned an important lesson – it's imperative that we continually ask ourselves how we can do better. The health care system must respond to people's unique and changing needs, adapt to shifting economic climates, and keep pace with technology and new insights. That is why it's crucial that we work together with our health service providers, community partners, residents, and the Ministry of Health and Long-Term Care to ensure people have access to the high quality care they need and deserve.

While I recognize there is still work to do, this LHIN has taken many steps to improve the health care system and people's experiences with it. I am confident it will continue to do so as it evolves as an organization, and as the world around us changes. With a board and staff who remain optimistic, dedicated and passionate about health system improvement, I am certain that we will continue making real progress in working toward a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren.

I take great pride in the work of our LHIN and I am grateful to work alongside a board and staff who share in my commitment to putting people first and harnessing the power of local decision-making.

I look forward to continuing to provide the people of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk with appropriate, coordinated, effective, and efficient health services.

Donna Cripps

Continued Evolution of the HNHB LHIN

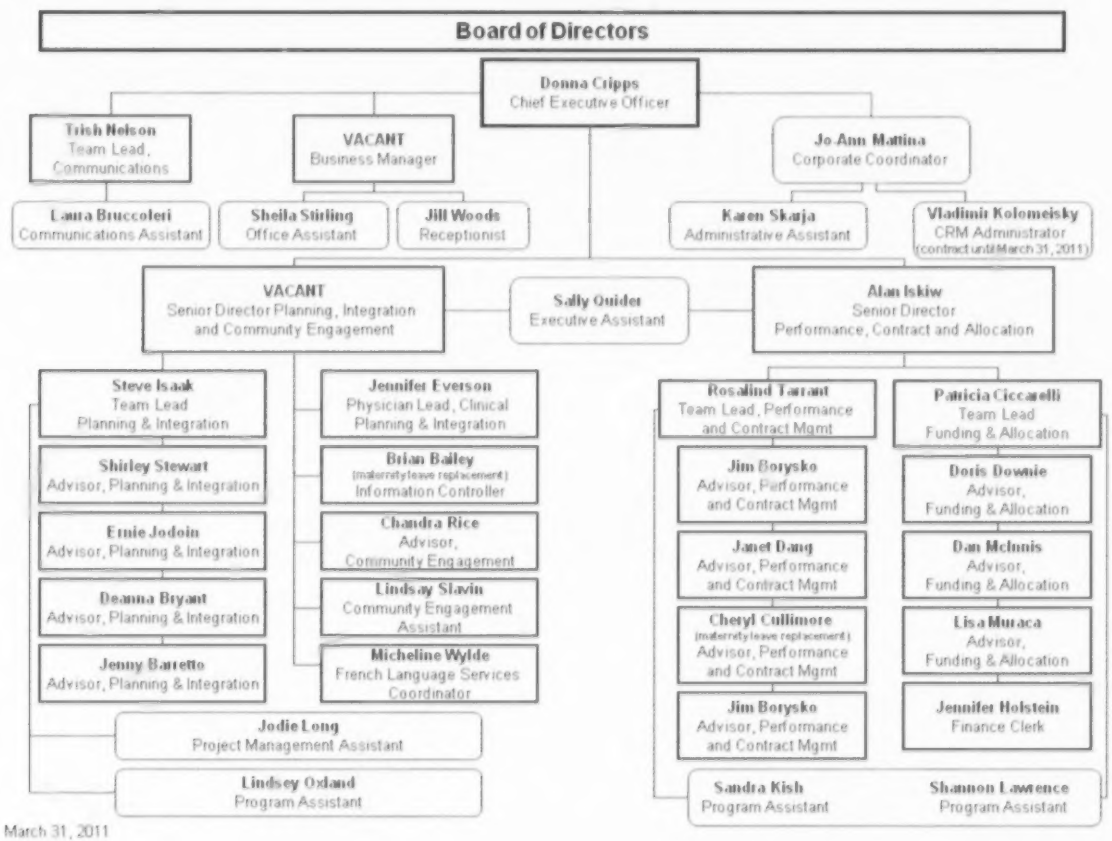
Our Organization

Staff

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren. It is this vision that guides them in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff remains committed to building capacity and sharing knowledge through further training and education, and participation in local, provincial, and national activities.

Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.



Board Members

In 2010-2011, there were three changes to the Board of Directors. Janice Mills completed her term on June 16, 2010 after an initial appointment of 13 months, followed by a three-year re-appointment. Helen Mulligan and Michael Shea both joined the board on June 17 and October 28, 2010, respectively.

Introducing Helen Mulligan and Michael Shea

Helen Mulligan, a resident of St. George, is a retired registered nurse who served at Brantford General Hospital and Cambridge Memorial Hospital. She was most recently chair of the Grand River Community Health Centre and in 2008 and 2009 was chair of the Brant County Health Unit. During this time she was also a member of the Brant Community Physician Recruitment Committee and chaired the Brantford General Hospital's 125th Anniversary Committee for 2008-2009. During her six year term of office as a municipal councilor of the County of Brant, Helen served as a board member of the Brant County Health Unit, John Noble Home for the Aged, Grand River District Health Council, Brant County Ambulance Committee and sat on the Governance Committee of council. Helen is also a member Glenhyrst Art Gallery of Brant, Ontario Genealogical Society and the Grand River Probus Club.

Michael Shea, a resident of Ancaster and born and raised in Hamilton, has been a member of the Hamilton Police Service for the past 35 years. He is currently the Superintendent in charge of Corporate Services. He is a graduate of the University of Western Ontario, Ivey School of Business, where he holds a Masters degree in Business Administration. Michael currently sits on the Board of Directors (Past President) of the Children's Aid Society of Hamilton, is a member of the Rotary Club of Hamilton A.M. (Paul Harris Fellow), and is an active volunteer with Good Shepherd Centres, the Community Child Abuse Council of Canada and the United Way of Hamilton-Burlington.

Relationship Between the Board and Senior Management

As of March 31, 2011, the LHIN Senior Team included the CEO, Senior Director – Performance, Contract and Allocation, and the Senior Director – Planning, Integration and Community Engagement.

Senior Team members attend the regular Board business and education meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- Regular business and education meetings
- Board committees
- Policy direction
- Performance appraisal

Snapshot of the HNHB LHIN

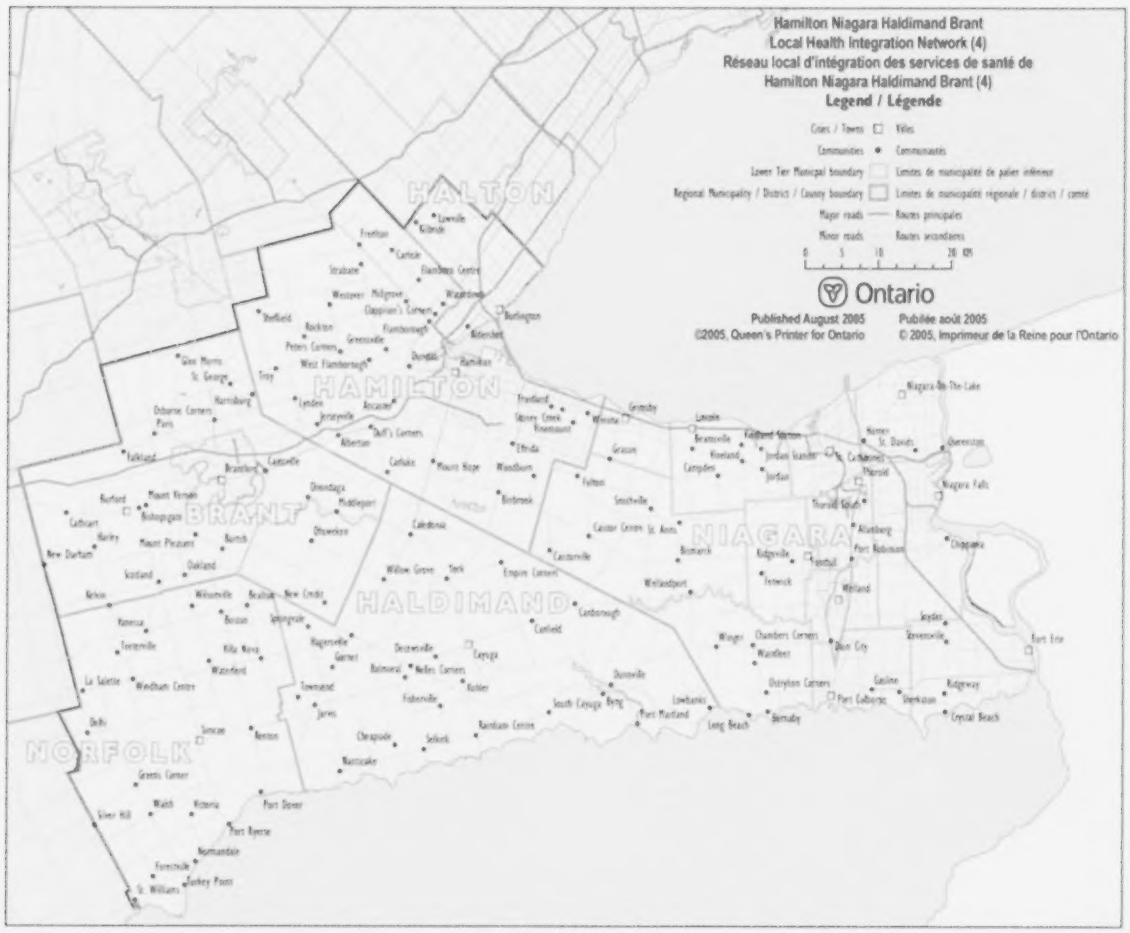
HNHB LHIN Population

Demographics

The HNHB LHIN is home to nearly 1.4 million people – about 11% of the population of Ontario. The HNHB LHIN population is estimated to grow 3.9% by 2015, and 8.5% by 2020 (Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).

While the total number of people 45-74 years old is growing the fastest, the largest changes will be among people age 85 or older (33.2%) and 65-74 (31.5%) over the next 10 years. This change shows that the HNHB LHIN's population is aging.

As of 2010, more than 225,000 seniors live in the HNHB LHIN which is the largest number of seniors of all Ontario LHINs (Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).



Socio Demographic Characteristics

The HNHB LHIN has a diverse population. For 18% of HNHB residents, neither English nor French is their fist language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. But compared to Ontario, the HNHB LHIN has a lower percent of immigrants and visible minorities.

There are two reserves in the HNHB LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Aboriginal population in the LHIN is approximately 24,000 people (1.7% of the total LHIN population) with about half the population living on reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates (Source: First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009).

HNHB LHIN has a higher percent of lone parent families, and lower percent of adults with post secondary education than the Ontario average.

	HNHB LHIN	Ontario	Range for all 14 LHINs
Total Population (2010)*	1,404,009	13,220,437	237,750 - 1,750,587
Senior population, age 65+ (2010)*	16.1%	13.9%	9.9% - 18.0%
Population with English mother tongue	79.2%	68.4%	49.6% - 90.9%
Population with French mother tongue	2.0%	4.1%	0.8% - 22.9%
Population who are immigrants	20.3%	28.3%	6.3% - 55.7%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%	0.3% - 9.5%
Populations who are visible minorities	9.1%	22.8%	1.4% - 50.3%
Population of Aboriginal identity	1.7%	2.0%	0.4% - 19.0%
Labour force participation rate (age 15+)	65.7%	67.1%	60.1% - 71.5%
Unemployment rate (age 15+)	6.0%	6.4%	5.2% - 8.4%
Population in low income (before tax) all persons	13.8%	14.7%	9.7% - 24.2%
Families (with children) headed by a lone parent	16.2%	16.0%	13.8% - 19.4%
Population (age 25-64) without certificate, degree, diploma	14.6%	13.6%	9.0% - 20.3%
Population (age 25-64) with completed post-secondary education	47.5%	52.7%	42.0% - 64.9%

*Source: *2010 population estimates. Remaining indicators based on 2006 Census of Canada, Statistics Canada*

Health Status

Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 60% of HNHB residents rate their health as 'excellent' or 'very good' (Source: Canadian Community Health Survey, 2009). However, significantly more HNHB LHIN residents say they are limited in activities because of a physical or mental condition or health problem.

Illness, Disease and Death

HNBH LHIN residents have significantly more arthritis/rheumatism, high blood pressure, and asthma compared to the province as a whole. Diabetes rates, on the other hand, are slightly lower (Source: Canadian Community Health Survey, 2009).

Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, and treating disease, and reducing suicide. In 2007, there were 11,594 deaths among residents of the HNHB LHIN. Heart disease, lung cancer, and stroke were the top three leading causes of death.

Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the HNHB LHIN are higher than provincial rates (Source: Deaths, Provincial Health Planning Database).

Health Practices and Preventive Care

Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the HNHB LHIN smoke daily or occasionally, drink heavily, and are obese (Source: Canadian Community Health Survey, 2009).

Preventive health care services can help find disease early, which over the long term reduces illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as whole. Within the last three years, 71.7% of women in the HNH BLHIN had a Pap smear (for cervical cancer screening), 73.1% of women received a routine mammogram in the previous two years, and 35.2% had a flu shot in the past year (Source: Canadian Community Health Survey, 2005, 2008 and 2009).

Most people get their care through their family doctors. Doctors also play key role in coordinating care and managing chronic conditions. Most people (82.1%) in the HNHB LHIN talked, either in person or by phone, with a doctor in the last year. This is similar to the Ontario rate of 82.9% (Source: Canadian Community Health Survey, 2009).

Summary

The HNHB LHIN covers approximately 6,500 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With approximately 1.4 million people, it includes small rural communities and large urban centres, with population that is culturally and linguistically diverse.

Relative to the province (Ontario), HNHB has a higher percent of:

- lone parent families
- people limited in their daily activities
- daily or occasional smokers
- people who are obese
- people with arthritis/rheumatism, high blood pressure, and asthma

The HNHB LHIN also has:

- the most seniors of any LHIN
- a higher rate of premature death and hospitalization
- a lower percent of adults with post-secondary education

Engaging our Communities

Community engagement is a core function of the LHINs. This function is written into the *Local Health System Integration Act,* 2006 which created LHINs. The Community Engagement (CE) Guidelines and Toolkit were implemented by all LHINs in February 2011 to promote standardization and best practices, and improve accountability. They outline requirements for an external review committee, an annual CE plan, and for including results in each LHIN's Annual Report. The Annual CE Plans, posted to LHIN websites on April 29, 2011, provide the public with information on upcoming engagement activities and goals, and how the community can expect to participate. The LHIN Community Engagement Guidelines and Toolkit is available to the public online.

As part of its work, the LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with Aboriginal, First Nations and Francophone communities. The HNHB LHIN recognizes, respects and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

LHINs are mandated to work with Aboriginal communities for improved health and wellness. The HNHB LHIN has a responsibility to learn about and respect Aboriginal communities' approach to health and wellness and how this approach guides the identification of health needs and solutions. Respect for and inclusion of Aboriginal traditional practices with non-traditional health providers is essential for health solutions aligned with cultural identity, holistic health, and community values.

The LHIN was involved in two projects that finished this year (funded through the Aboriginal Health Transfer Fund) to support healthy families and healthy children:

- The Children's Mental Health and Wellness Project identified gaps in services and supports for Aboriginal children and families involved, or at risk of being involved, in child welfare in the HNHB LHIN region. This project involved exploring and developing a support network to address children's needs; specifically, coordinated children's mental health care. More than 100 interviews were completed with Aboriginal and mainstream frontline workers and professionals, as well as Aboriginal parents and caregivers to learn about people's experience with mental health services for children in the LHIN.

- The Aboriginal Hospital Discharge Planning project improved the transition from one level of care to another for First Nation people living on reserves. A discharge planning committee drafted a model of care, directory of resources, and policies and procedures for discharge planning for Six Nations Long-Term Care Home and community care case managers. The committee included stakeholders from area hospitals, the HNHB Community Care Access Centre (CCAC) and other interested parties.

Outcomes of Aboriginal Health Engagement:

- ✓ Reduced burden of illness among Aboriginal people on dialysis
- ✓ Fewer emergency room visits by Aboriginal people living with mental health and addictions and substance use issues
- ✓ Aboriginal communities, stakeholders, and networks are actively involved in planning and decision- making

The LHIN, St. Joseph's Healthcare Hamilton, and the Ministry of Health and Long-Term Care worked collaboratively to establish a new dialysis unit at Six Nations. The new *Gil Martin Dialysis Unit* is equipped to provide dialysis treatment for 12 patients. The greatest benefit of the unit to patients is the reduced travel time. Prior to the opening of this unit, residents of Six Nations and nearby areas had to travel to Hamilton or elsewhere for dialysis treatment and now this treatment is available closer to home.

As part of the Ontario government's commitment to improve access to mental health and addiction services, the Ministry of Health and Long-Term Care funded new supportive housing units and addiction case management services for homeless people with problem substance use issues. The HNHB LHIN was allocated funding to support a total of 128 housing units and 16 case management positions over three years (2009-10, 2010-11 and 2011-12), which the LHIN allocated according to population distribution and client need. The LHIN implemented 16 supportive housing units for Aboriginal persons with addictions; eight at Six Nations and eight in Brantford.

The Aboriginal Palliative Care Network is working to design and implement an integrated model of hospice care service delivery within local Aboriginal communities. As part of this process, the Network held a strategic planning session on December 2, 2010, which was partially funded by HNHB LHIN. More than 60 people participated in this session, including researchers, community providers, the HNHB LHIN Hospice Palliative Care Network, partners from local hospitals and Community Care Access Center palliative care. The strategic planning day laid the groundwork for the future development of the Palliative Care team.

After its original convening, the Aboriginal Health Network went through a period of ambiguity around their role in the system and how to work with the LHIN, however toward the end of the year, the Network found new energy and leadership and has been revitalized. They are now meeting regularly and are looking forward to take on a larger role in improving Aboriginal health in the LHIN.

Francophone Health Engagement

The French Language Services Act, Ontario, 1986, recognizes the contribution of the French speaking population to the historical, cultural and linguistic heritage of Ontario. The Act guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. To this end, LHINs plan and promote French language health services and engage the French speaking community in the process. The goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

The regulation made under the *Local Health System Integration Act, 2006* for Engagement with the Francophone Community was adopted in January 2010.

The regulation states that the local health integration network shall engage its French Language Health Planning Entity to advise the LHIN on:

- methods of engaging its Francophone community;
- the health needs and priorities of its Francophone community, including the needs and priorities of diverse groups within that community;
- the health services available to its Francophone community;
- the identification and designation of health service providers for the provision of French language health services in the LHIN;

- strategies to improve access to, accessibility of and integration of French language health services in the local health system; and,
- the planning for and integration of health services in French in the LHIN.

In December 2010, the *Entité de planification pour les services en français dans les régions Waterloo-Wellington, Hamilton-Niagara* was named the Planning Entity shared by the HNHB and Waterloo Wellington LHINs. Dialogue with the Planning Entity has begun, and in March 2010, an accountability agreement was signed.

The Regional French Language Services (FLS) Coordinators of the Ministry of Health and Long-Term Care were transferred to the LHINs in the course of the last year.

The mandate of the FLS Coordinator in HNHB LHIN is:

- to increase knowledge and awareness of French Language Services in order to improve access to quality health services in French;
- to ensure FLS processes are integrated into all the work of the LHIN as a Crown agency and as a planning body;
- to engage and liaise with health service providers to help them plan and implement French Language Services for their Francophone clients; and,
- to liaise with the Francophone community on an on-going basis to identify issues and to increase knowledge and awareness of FLS planning and implementation by the LHIN.

The Centre de santé communautaire Hamilton-Niagara is providing significant leadership for Francophone engagement in the LHIN. With support from the LHIN, the Centre de santé communautaire Hamilton-Niagara held a forum in March 2010, for Francophone youth in Hamilton. This was to provide them with an opportunity to voice their concerns about current health, social and cultural matters, to identify shortcomings in service delivery and offer ways to improve access to services and programs in French.

Stakeholder Engagement

As part of a stakeholder engagement strategy, HNHB LHIN Board and staff members meet with political representatives throughout the year. Representatives from MPP Constituency Offices were invited to meet with the LHIN CEO and staff in March 2010. In addition, several individual meetings with most MPPs within the LHIN region were held. The focus of these meetings was to keep political representatives informed of HNHB LHIN initiatives and activities as well as to provide a forum for discussion about community health care needs, issues and concerns.

The *Local Health System Integration Act, 2006,* (LHISA) requires that the HNHB LHIN sign a Multi-Sector Service Accountability Agreement (M-SAA) with each health service provider that it funds. In 2010-11, the HNHB LHIN worked toward signing its second accountability agreement with health service providers in the community sector, including community support services (55), community health centres (7), mental health and addictions organizations (36) and the HNHB Community Care Access Centre (CCAC). This year's M-

SAA is a three year agreement (2011-2014); one year longer than the first M-SAA that was signed for 2009-2011.

LHIN staff held two face-to-face orientation sessions for its 99 community health service providers to give them an overview of the Community Accountability Planning Submission (CAPS) and M-SAA to help support their completion. The session allowed LHIN staff to help providers understand how to complete this important submission, and also created a forum for discussion where providers had the opportunity to ask questions. LHIN staff subsequently held two supplementary education webinars. In addition to providing *Frequently Asked Questions* to the community health service providers, we invited each organization to individual meetings (as needed), to support them through the process of completing the M-SAA.

In 2010, the LHIN signed is first Service Accountability Agreement (SAA) with 86 long-term care homes (LTCH) funded by the HNHB LHIN. To comply with its legislative requirements the LHIN was initially expected to have a new agreement signed with each LTCH by April 1, 2010. However, in order to align the new agreement with the proclamation of the new *Long-Term Care Act, 2007*, which became law on July 1, 2010, the previous agreement which the LHIN assumed from the Ministry of Health and Long-Term Care, was extended to June 30, 2010.

To share details of the new SAA and to educate LHIN-funded LTCHs on the terms of the new agreement, the LHIN hosted two half-day information sessions and a webinar. The LHIN also met with any LTCH that requested a one-on-one meeting. The LTCH SAA is a three-year agreement that outlines expectations and accountabilities for the LHIN and LTCH for the funding provided. As of July 1, 2010, the LHIN had signed agreements with all 86 LTCHs.

CEO Meet and Greets

Throughout November 2010, seven informal 'Meet and Greets' were held across the LHIN to provide an opportunity for CEO Donna Cripps and health service providers to get acquainted one-on-one. Donna had just joined the LHIN in October 2010. Nearly 80 representatives from long-term care homes and community support services attended.

The informal and intimate setting allowed attendees to share their thoughts on health care related issues with LHIN leadership. This was also an opportunity for Donna to create new and strengthen existing relationships with local health service providers, and to gain insight into how the LHIN can foster an environment for further collaboration among providers.

Aiming for Better Health: Fort Erie

A two-part forum to enhance chronic disease prevention and management (CDPM) in Fort Erie was held on November 22 and 30 2010. Using the Triple Aim framework, participants identified local priorities related to CDPM and, as a group, built an action plan to improve the health of their community. Approximately 60 people, including health service providers, community and social service agencies, and citizens, participated in the event.
The Triple Aim framework, developed by the Institute for

Healthcare Improvement (IHI), balances three health system goals: improving the health of the population, enhancing the experience of care, and fiscal sustainability.

As a result of the forum, the participants organized themselves into four working groups related to specific strategies for the two main goals indentified. The working groups meet regularly to move these goals forward.

To prepare for the forum, the LHIN undertook a series of community engagement activities, including:

- 18 key informant interviews with 24 individuals that provide various services to Fort Erie residents;
- six focus groups with more than 60 residents to discuss CDPM; and,
- an extensive review of community engagement reports from organizations in Fort Erie.

Participants developed two main goals to enhance CDPM in Fort Erie:

- ✓ Reduce by 20% the number of emergency room visits and hospitalizations among vulnerable populations (for example, seniors, persons with low income, or persons with mental health and addictions conditions) by 2012
- ✓ Decrease by 2% the obesity rate in Fort Erie by 2015

Insight from this preparatory work, as well as information and data about the population and services in Fort Erie helped the community build its plan. To learn more about the forum, visit the HNHB LHIN YouTube channel at www.youtube.com/user/hnhblhin. The Triple Aim initiative to enhance CDPM will continue next in Haldimand-Norfolk and Downtown Hamilton.

Engaging the Community Together

On October 27, 2010, the HNHB LHIN hosted a meeting that brought together leads and members of local networks to meet and discuss their role in engaging the community. It was a great opportunity for networks within the LHIN to get to know each other.

In attendance were approximately 35 people, from a cross-section of organizations including mental health and addictions, supportive housing, acquired brain injury, and community support services. Based on discussions, the LHIN created and distributed an online database of networks in the LHIN to aid in collaboration amongst them.

Physician Engagement

Physician involvement, uptake and support are integral to the successful implementation of the LHIN's priorities, including interprofessional care, clinical program integration and community-based health service capacity improvements across our communities and our hospitals. The HNHB LHIN has made significant strides in engaging physicians.

Key to this success is Dr. Jennifer Everson, the LHIN's Physician Lead, Clinical Planning and Integration. Dr. Everson liaises between the HNHB LHIN and the Michael G. DeGroote School of Medicine to facilitate the integration of clinical, teaching and research activities across the HNHB LHIN.

The recognized need for physician involvement in LHIN initiatives as key to driving and supporting positive change in the health care system led to the establishment of the Primary Care Network. This network includes representatives from hospitals, Community Health Centres, Family Health Teams, Family Physicians Association of Hamilton, primary care, diabetes leads, public health, the Ontario Medical Association (OMA), the Ontario College of Family Physicians (OCFP), and Cancer Care Ontario (CCO). One of the things this committee is focusing on is cancer screening throughout the LHIN.

The LHIN's work in creating a Primary Care Network helped to inform the subsequent development of a provincial resource guide and toolkit for engaging physicians in LHIN processes. This toolkit also endorses the role of a 'Primary Care Physician Lead,' much like the role Dr. Everson plays with the HNHB LHIN.

In addition, the LHIN meets monthly with and provides support to the Chief Medical Leaders Group, which is comprised of hospital Chiefs of Staff and Vice Presidents of Medical from the LHIN region. This group plays an important role in helping to advance LHIN and Ministry priorities.

In the past year, the Chief Medical Leaders group has:

- discussed the *Excellent Care for All Act (ECFAA)* and how it impacts the role of hospital Medical Advisory Committees;
- held an education session for physician leaders in HNHB LHIN hospitals;
- developed a common credentialing and re-credentialing hospital application form; and,
- provided input into the work of the LHIN's Clinical Program Integration task groups.

In an effort to enhance patient safety and access to care, the LHIN brought together radiology Chiefs of Staff from each of its 10 hospitals. This group identified several opportunities to work together to standardize processes and improve outcomes for their patients. The group decided to implement the Interventional Diagnostic Imaging (DI) checklist within each of their hospitals, modeled after the provincial surgical checklist.

In May 2010, Dr. Jennifer Everson was appointed as the LHIN liaison with McMaster University's Faculty of Health Sciences. The faculty provides active leadership for advancing the education and training of future health care professionals in diverse health settings in communities across the LHIN, alongside Mohawk College and Brock University. In this leadership role, she is advancing interprofessional care, optimal practice scope, best practices, and distributive medical education across the LHIN.

Fostering Collaboration and Enhancing Quality

HNHB LHIN RNAO Best Practice Spotlight Organization Candidacy

The HNHB LHIN is one of 16 sites across Ontario that has been given the opportunity by the Registered Nurses Association of Ontario (RNAO) to become a Best Practice Spotlight Organization (BPSO). During the second year of this unique three-year candidacy, 12 organizations have continued to share resources and worked collaboratively to implement and evaluate RNAO Best Practice Guidelines (BPGs) across the continuum of care.

Throughout the second year, organizations continued to implement standardized practices from the following BPGs:

- Prevention of Falls and Fall Injuries in the Older Adult; and,
- Risk Assessment and Prevention of Pressure Ulcers.

Organizations use risk assessment tools and a common reporting system that facilitates quarterly monitoring of client outcomes. They also collectively developed a LHIN-wide policy to standardize and promote best practices when transferring patients between participating organizations.

Participating organizations include:

- Brant Community Healthcare System
- Haldimand War Memorial Hospital
- Hamilton Health Sciences
- HNHB Community Care Access Centre
- Hotel Dieu Shaver Health and Rehabilitation Centre
- Joseph Brant Memorial Hospital
- Niagara Health System
- Niagara Region Public Health
- Norfolk General Hospital
- St. Joseph's Healthcare Hamilton
- West Haldimand General Hospital
- West Lincoln Memorial Hospital

The research study entitled, *Implementation of a Falls Prevention Guideline across the HNHB LHIN: A Longitudinal Study of Outcomes*, that was funded by the RNAO in year one continues. In year three, the outcomes associated with the implementation of the Falls guideline will be reviewed and standardized practices will continue to be implemented.

The HNHB LHIN BPSO Candidate has met all RNAO contract requirements to date and is on track to receive BPSO designation in March 2012.

Residents First

The HNHB LHIN is involved in a quality improvement initiative known as Residents First. This initiative supports long-term care homes in Ontario in providing an environment for their residents that enhances their quality of life. Residents First also facilitates comprehensive and lasting change by strengthening the long-term care sector's capacity for quality improvement.

Participating homes focus on:

- ✓ Avoiding unnecessary transfers to emergency rooms
- ✓ The caregiver-resident relationship
- ✓ Preventing falls and pressure ulcers
- ✓ Continence care
- ✓ Medication safety and behavioural supports
- ✓ Enhancing care documentation

A series of learning and sharing sessions took place over the past year, where representatives from the LHIN's long-term care homes gathered to learn about the initiative and share resources and success stories.

Residents First is a provincial initiative made possible through the support of the Ontario Ministry of Health and Long-Term Care. Implementation is a team effort involving LHINs as well as organizations representing residents, their families and homes. These groups have input on an ongoing basis, as members of the provincial steering committee that is guiding the implementation of the initiative.

Health Professionals Advisory Committee (HPAC)

Since its inaugural meeting in March 2008, members of the Health Professionals Advisory Committee (HPAC) have played an important role in bringing issues forward from each of their respective roles and professions.

In 2010, a sub-committee of HPAC formed to explore opportunities to optimize interprofessional care and scopes of practice within the LHIN. After a literature review and discussions with other health professionals, the subcommittee brought five recommendations to HPAC which it accepted at its September 2010 meeting. The recommendations were discussed with the Chief Medical Leaders at HNHB LHIN hospitals and further engagement with residents and health care professionals will take place as HPAC develops a strategic implementation plan.

As members' terms came to completion as outlined in HPAC's Terms of Reference, a new Chair and Vice Chair were appointed at the committee's November 2010 meeting. Over the course of the last year, one member resigned and recruitment to fill this position and one additional (optional) position will be begin in April 2011.

Moving our Priorities Forward

Now in the second year of implementation, the HNHB LHIN and its partners are making great progress in advancing its priorities as outlined in the Integrated Health Service Plan (IHSP) 2010-2013. The themes from the Clinical Services Plan, approved by the HNHB LHIN board in November 2009, are tightly woven into the IHSP, which was approved by the board in December 2009.

Patient Flow -
Helping People get the Right Care, at the Right Time, in the Right Place
Alternate Care Settings
Emergency Department Capacity
Clinical Program Integration
Community Based Health Service Capacity
Aboriginal Health
Francophone Health
Chronic Disease Prevention and Management -
Reduce Prevelance of Chronic Disease and Improve Care Delivery
Mental Health and Addictions -
Linking Services for Prevention, Management and Recovery
Enablers for Transformation
eHealth
Inter Professional Care
Transportation
Partners for Change

Overview of Priorities, page 11, IHSP 2010-2013

Integration

One of the key purposes of the *Local Health System Integration Act, 2006* is to: *"Provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs)."*

LHINs and health service providers have an obligation under the Act to identify opportunities to integrate services, whether through coordination and partnerships, or through transfer of service and amalgamation. This past year, the LHIN worked with its health service providers on the development of a number of LHIN-wide integrated clinical programs.

The goal of Clinical Program Integration (CPI) is to integrate service delivery for selected clinical areas into LHIN-wide coordinated programs to improve efficiency, access and quality of care. The size and location of services are based on population needs. The successful implementation of LHIN-wide service delivery models depends on leadership, shared accountability, connectivity and the standardization of definitions, processes, tools and protocols to optimize communications and timely access to cost-effective, quality care.

Impact of CPI:

- ✓ Improved quality, efficiency and access to care
- ✓ Standardized care processes
- ✓ Streamlined care
- ✓ Expertise in centres of excellence

Throughout 2010-11, six program areas were selected to move forward with integration: Complex Care, Laboratory Medicine, Rehabilitation, Cancer Care, Vascular and Thoracic. While the structure of the implementation committees and the relative need for LHIN leadership or support varies by program area, the LHIN provided all groups with planning intelligence, along with common processes, tools and templates to help ensure there is a consistent approach to implementation across programs. Integrated program frameworks have been completed or are nearing completion in each of these areas.

Each of the six programs engaged hospital CEOs, members of the senior team, physicians and appropriate members of the management group in the development of the plans. The Community Care Access Centre (CCAC) and stakeholders from other organizations were engaged during the planning and development of the new model for the purpose of developing the future state. This included any health service providers and community support services that were stakeholders in the new model. Engagement occurred monthly with some plans and more or less frequently with others. Engagement was in the form of surveys, planning meetings and written feedback. The result was support for the new model and clear implementation plans.

Interprofessional Care

The HNHB LHIN has an aging population with increasing health care needs and a high proportion of residents with one or more chronic diseases, such as diabetes and chronic obstructive pulmonary disease (COPD). Many residents, for a variety of reasons, suffer from obesity, which also leads to many health concerns. Assisting residents with their health care needs requires a variety of health professionals, making up interprofessional care teams. Interprofessional care improves people's health care experience and health outcomes, and improves provider satisfaction. Work is underway to advance interprofessional care across the LHIN.

Over the past year, the Health Professionals Advisory Committee (HPAC), which consists of physicians and other allied health professionals, began to move forward on enhancing interprofessional care across the LHIN *(see page 22 for more information)*.

An interprofessional care team was established at Joseph Brant Memorial Hospital (JBMH) in Burlington to provide comprehensive assessments to seniors. This Geriatric Assessment Intervention Team (GAIT) clinic allows family physicians, geriatric nurse practitioners, social workers, dieticians and specialists, to all work with seniors and their families to provide the appropriate care and advice. This also prevents these patients from having to be seen in JBMH's emergency room.

In the development of the clinic, input was sought from a variety of health care professionals, including primary care physicians, and patients and their families in Burlington. The GAIT clinic receives excellent feedback from patients and their families, and from primary care physicians. A toolkit was created and is available to help other hospitals in the LHIN and the province to develop a similar GAIT clinic.

Community-Based Health Service Capacity

The LHIN's Clinical Services Plan (CSP) identified challenges within community-based health services, including: system navigation, variation in availability and access to services across the LHIN, and variation across the community sector related to assessment tools, referral practices, care planning, support for self-management and client health outcomes.

Linking People with the Right Community Services

The HNHB LHIN introduced a common assessment tool - InterRAI CHA (InterResident Assessment Instrument Community Health Assessment) - in the Community Support Services (CSS) sector.

The benefits of Community Support Service agencies using this tool include:

- assists clients in accessing the most appropriate available services
- reduces duplication of assessments
- informs service plans
- further develops the practice of assessment and care planning
- informs decision-making and planning based on standardized, aggregate data
- facilitates inter-agency communication through a common language based on recognized data standards

Planning began in 2010-11 with implementation planned in three phases beginning in April 2011 and completed by February 2012. A LHIN-wide InterRAI CHA Advisory Group met regularly and provided direction for the implementation of the tool.

This engagement has resulted in:

- endorsement of the tool for the benefit of clients
- a request to Community Care Information Management (CCIM) for the HNHB LHIN to pilot the tool
- agreement on timelines for training and implementation
- the identification of key issues and recommendations for a tailored approach to implementation that meets the needs of the HNHB LHIN
- ongoing discussions on client flow, care paths and the circle of care

Linking the Right People with Food Services

The HNHB LHIN introduced a nutritional risk assessment screening tool in all LHIN-funded food programs. After a year of engaging the CSS sector, the LHIN was excited to see the full implementation of a nutritional risk assessment screening tool to prioritize client service needs and optimize the use of resources. This means that the seniors who have the highest nutritional needs are the most likely to receive services. Data shows that from the screening completed, most of the people who are currently getting meals are identified as high nutritional-risk.

Better Access to Transportation

Improved access to transportation was identified as a key priority in the LHIN's Integrated Health Service Plan (IHSP) 2010-2013. In July 2010, a transportation workshop was convened with a cross section of

stakeholders to begin to identify ways to improve access to transportation and to make better use of existing resources.

Key needs identified at the workshop were the need for common assessment, a single point of access, and improved, integrated technology for intake/assessment and scheduling. The group identified that the next step was to find what programs were available in the community, and for what purposes residents use transportation services.

The LHIN established a Transportation Advisory Working Group (TAWG) to advise the LHIN on strategies to improve transportation. Its primary role was to submit a plan to optimize LHIN-funded transportation resources to improve access. To support this activity, the TAWG:

- Developed a common eligibility framework to promote equitable access to LHIN-funded transportation.
- Created an inventory of LHIN-funded and non-LHIN funded community transportation services.
- Conducted a two-week census of the utilization of all LHIN-funded transportation services including client demographics, client needs, and destinations.
- Conducted a review of transportation coordination models employed in other Ontario communities that improve resident access and coordination.
- Identified best practice models and issued a Request for Business Case to agencies to develop a proposal for a LHIN-wide coordinated system of transportation.

A major success was the ability to involve key transportation stakeholders who over a series of meetings, reached consensus on an evidence-based coordination model and are in the process of developing a business case for submission to the LHIN. The development of common eligibility criteria was another key milestone. By completing the resource inventory and census, the TAWG realized both the problems with access (unfilled rides), and the potential to free up resources through coordination.

Better Access to Assisted Living Services

Research identified the greatest gap in the community sector in the HNHB LHIN is in assisted living/supportive housing for seniors. Inadequate access to assisted living services in the community for seniors in poor health leads to early admissions to long-term care, and contributes to high rates of emergency room visits and the number of days people spend waiting in hospital to move to a different care setting.

The LHIN established partnerships and a project plan to develop a demonstration model to enhance the capacity of assisted living services to serve seniors in poor health in their own homes and in supportive housing settings. This model aligns with the updated *Assisted Living Services for High Risk Seniors Policy, January 2011*, from the Ministry of Health and Long-Term Care. The demonstration model will begin in May 2011.

Engagements with seniors and service providers were undertaken to identify seniors ALS service needs and opportunities among local service providers for partnerships to address these needs in an efficient and effective manner. Engagements with service providers ramped up towards the end of the year, with bi-weekly meetings. Engagements with seniors happen on a daily basis and are facilitated by the service providers who share any outstanding issues with the LHIN.

Seniors focus groups were convened at the site of the Assisted Living Services demonstration model to introduce seniors to the new services that will be provided and to obtain their feedback on what services they need and how they would like to access these services.

The result is a strong collaborative partnership among health service providers and strong uptake by seniors receiving these services.

Mental Health and Addictions

One in five persons or 280,000 people, in the HNHB LHIN will be affected by mental illness at some point in their lives (Source: Health Canada, A Report on Mental Illness in Canada, 2002). Approximately 42,000 people, or 3% of people in the LHIN, depend on alcohol or illicit drugs in a given year (Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008). Key issues facing people with mental health and addictions include social stigma, access to services and basic supports including housing, income and social inclusion.

Planning

The HNHB LHIN hosted a focus group with key stakeholders from various care settings on the provincial government's report *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy,* released December 2010. This resulted in a more in-depth understanding and ratification of the report and the identification of priority areas for health service providers and consumers for consideration in 2011-12.

In the HNHB LHIN:

- 10-20% of residents will have a substance use disorder in their lifetime.
- 70% of people with mental health issues have been diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

Local networks in Hamilton, Haldimand Norfolk, Niagara and Burlington as well as the LHIN-wide Mental Health and Addictions Network have been actively working on LHIN priority areas. Some examples include improved access to psychiatrists, implementation of a common assessment tool, and reducing repeat unplanned visits to emergency rooms.

These networks meet on a monthly basis and input collected from these meetings has shaped the LHIN's approach to planning. Each geographic area of the LHIN has a different array of services available, needs of the mental health and addictions clients, issues related to access, clinical specialty expertise and rural/urban composition. This means a 'one size fits all' approach to planning will not be successful and engagement of local providers and consumers is essential to successful planning and implementation.

In addition, the HNHB LHIN has worked collaboratively with the Centre for Additions and Mental health to sponsor best practice forums.

Identifying Areas for Health System Improvement

Over a one year period, 30 individuals with a mental health issue and/or addiction accounted for nearly 2,200 visits to hospital emergency rooms. An analysis was conducted to understand why this occurred and

to help identify areas for health system improvement. Representatives of LHIN hospitals and community-based mental health and addictions providers met regularly to discuss this and have agreed to pilot a consistent approach to address this issue.

Through this collaborative approach between hospital and community providers, system-wide improvements, issues and gaps in service will be identified. This will shed light on how the system can be more responsive to meet people's needs.

Better Access to Mental Health and Addictions Services

A wide variety of programs and services have been funded to meet the mental health and addictions needs of residents in the HNHB LHIN, including:

- A 24-7 crisis call service and mobile mental health crisis service providing outreach with policy, nurses and social workers through implementation of the Crisis Outreach and Support Team Niagara (COAST) – Canadian Mental Health Association Niagara is the lead organization
- Improved access to specialized geriatric services in Niagara and Haldimand Norfolk through Niagara Health System and St. Joseph's Healthcare Hamilton.
- First Link for persons with dementia and their caregiver through the Dementia Alliance
- Day program for people with early stage dementia in Brant County through the John Noble Centre Day and Stay Program
- Community Re-engagement program through the Regional Municipality of Niagara and Linhaven Home for the Aged.

Expansion of Supportive Housing and Case Management for Persons with an Addiction

Funding was provided to support 128 housing units and 16 case management positions over three years (2009 to 2012) for people with problematic substance abuse, for example, people who frequently and repeatedly use withdrawal management services.

This funding will:

- Reduce the frequency of admissions to withdrawal management services
- Provide better housing stability for people with problematic substance abuse who are homeless or at risk
- Reduce pressure on hospitals and emergency rooms

Linking People with the Right Services

The HNHB LHIN will be introducing the Ontario Common Assessment of Need (OCAN) tool with all mental health service providers. This tool will identify individuals' needs and help match them to existing services. It will also help to identify any gaps in service. A LHIN-wide advisory group has been established to support the process of implementing the tool. Consultation with provider organizations and consumers has resulted in a tailored approach that meets the specific needs of the HNHB LHIN. The tool will also help to inform local, regional and provincial planning and decision-making, and will facilitate communication among mental health service providers.

Increased Access to Psychiatrists

New sessional fee funding provides people with increased access to psychiatrists across the LHIN. Planning is aligned with the current provincial goals of addressing unattached patients, easing pressure on emergency rooms, and the provincial strategy on mental health and addictions. Planning has been directly informed through consultation with the local Mental Health and Addictions Networks as well as the HNHB LHIN Sessional Fee Advisory Group

Chronic Disease Prevention and Management

More than one million people in the HNHB LHIN report having a chronic condition, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). This number is steadily rising due to the LHIN's aging population. Among residents with diabetes, complications are experienced by many; each year more than 200 people in the HNHB LHIN have a foot or lower limb amputated due to complications with diabetes. A number of activities over the past year have contributed to better care for people with chronic conditions.

Uptake of Best Practice

Approximately 100 health service providers, including family physicians, nurse practitioners, and other allied health professionals, attended the third annual *Raising the Bar in Chronic Disease Prevention and Management* Continuing Health Sciences Education Event. This annual event aims to build capacity among health service providers to increase the uptake of best practices among health service providers.

The development of a Primary Care Network helped the LHIN to identify priorities for action and assisted in broader communication with other health professionals.

Better Access to Diabetes Services

The LHIN enhanced coordination and improved access to diabetes service by helping to identify and implement more local Diabetes Education Programs and by working with health service providers to identify opportunities to expand foot care services for people with diabetes. The LHIN implemented peritoneal dialysis in three long-term care homes. In addition to working with its partners to establish a new Self-Management Coordinating Centre, the LHIN also continued its partnership with the Diabetes Regional Coordinating Centre to develop a LHIN-wide approach to diabetes care. These activities helped to achieve the goals of the Ontario Diabetes Strategy.

Community Empowerment

A two-part forum to enhance chronic disease prevention and management (CDPM) in Fort Erie was held on November 22 and 30 2010. Using the Triple Aim framework, about 50 participants identified local priorities related to CDPM and, as a group, built an action plan to improve the health of their community. The Triple Aim framework, developed by the Institute for Healthcare Improvement (IHI), balances three health system goals: improving the health of the population, enhancing the experience of care, and fiscal sustainability.

The participants organized themselves into four working groups who are concentrating their efforts on the priorities indentified:

- Reduce emergency room visits and hospital stays among long-term care home residents

- Improve access to care for people with at least one chronic condition
- Increase opportunities to help people with chronic conditions take care of themselves
- Reduce the obesity rate in Fort Erie

Work is underway with Haldimand-Norfolk, the next community where Triple Aim will be applied (see page 18).

Aging at Home

Aging at Home (AAH) is a strategy that provides a continuum of community-based services for seniors and their caregivers to allow them to stay healthy and live independently and with dignity in their homes. The strategy also aims to decrease the number of alternate level of care (ALC) patients in Ontario hospitals. ALC patients are individuals who are occupying acute care beds in hospitals, but would be better cared for in another setting, for example, in their own homes, supportive housing settings, or long-term care homes.

Through the Aging at Home Strategy, the HNHB LHIN has received more than $33 million to fund local programs that provide health services to seniors in the community, enabling them to lead healthy and independent lives while avoiding unnecessary visits to hospitals. Now in its third year (2010-11), most programs funded through AAH have been operational for two years.

This year, the HNHB LHIN evaluated the programs funded in the first two years to ensure that they are meeting their intended objectives and are contributing to improved population health, client outcomes, and system sustainability. In October 2010, 67 programs submitted their second quarter performance and financial reports.

In year three, the LHIN implemented six new programs, all of which focus on getting people the right care in the right place, getting them home safely and quickly after a hospital stay, and finding them supports in the community rather than the emergency room.

One of the new programs funded in year three was a Rapid Access Clinic. This model is an innovative opportunity to have traditional emergency room (ER) based general internal medicine consultations occur outside the ER within 24 to 48 hours of a patient's ER visit. People now have rapid access to internal medicine assessments delivered through an interprofessional approach at Hamilton Health Sciences, Joseph Brant Memorial Hospital, and St. Joseph's Healthcare Hamilton.

As a system level measure the LHIN monitors the percent of residents admitted to long-term care homes and the number of residents receiving services from the Community Care Access Centre (CCAC) with high or very high MAPLe scores. Since April 1, 2009, the percent of clients placed in long-term care homes with high or very high MAPLe scores has continually increased.

The CCAC uses the Method for Assigning Priority Levels (MAPLe) tool to assist in the identification of clients who are likely to require admission to a long-term care (LTC) home. Clients in the low category have no major functional, cognitive or environmental problems. They would not be at great risk of adverse outcomes and therefore would be unlikely to require admission to LTC. Clients in the very high category are identified at risk of adverse outcomes based on greater problems in cognition, ability to perform daily living activities, and/or behaviour.

In addition, the number of clients with high and very high MAPLe scores being supported in the community has increased.
Outcomes include:

- reduced caregiver burden
- deferred long-term care home placement
- reduced lengths of stay in hospital
- improved access to primary care and specialized geriatric services
- reduced avoidable hospital stays and emergency room visits
- improved health and functional status
- more effective use of resources

While this system change cannot be attributed to any one factor, it may be reflective of increased resources available in the community to support individuals to remain at home longer.

eHealth

The e-Health Project Management Office (PMO) for the HNHB LHIN plays a lead role in harnessing information technology and innovation to improve patient care, safety and access for the residents of the LHIN in support of the government's health strategy.

Provincially, the e-Health Ontario office continued to implement a new management team and governance. Concurrent with these changes, there has been a shift from a centralist model for e-Health to one where regional hubs are able to move and share local data.

The PMO and many other health care partners in the LHIN have made significant achievements in the past year. This group of passionate stakeholders is participating in a number of transformational projects that are making a difference in the HNHB LHIN today including:

- ClinicalConnect as a 'Virtual Health Record'
- Integrated Decision Support
- Single incident occurrence and reporting system for the LHIN
- Single Alternate Level of Care Information System (ALCIS)
- Group procurement for hardware and software
- Memorandum of Understanding between providers that agrees to standardize and work together

ClinicalConnect

ClinicalConnect is a secure, provider portal or dashboard that gives authorized physicians and health care providers involved in a patient's circle of care, real-time, anytime and anywhere access to electronically stored patient records. ClinicalConnect is an integration framework that is key to the access and sharing of health information regionally across the continuum of care including provincial data sources as they become available.

Today, ClinicalConnect provides a virtual Electronic Health Record for the HNHB and Waterloo Wellington (WW) LHINs, representing more than two million patients. It links data from 27 hospitals across the two LHINs. Also included is the Juravinski Cancer Centre oncology notes and HNHB Community Care Access Centre (CCAC) information. West Lincoln Memorial Hospital, WW CCAC, Grand River Hospital and Cancer Centre are targeted for 2011.

Integrated Decision Support (IDS) Warehouse

IDS is a powerful clinical decision support system that supports more timely and improved health care utilization and planning. IDS is a centralized data warehouse containing current, detailed information for patients in hospital beds, emergency room visits, same day surgery, medical day care clinics, CCAC client and assessment data, and Community Health Centre (CHC) client and provider data.

It is linked by an identification that is specific to an individual that connects data from all data sources that allows users of the IDS to follow a patient's journey through the health care system. In addition to a patient's clinical information, hospital-specific financial and statistical information are available for three year trending. Over 10 hospital corporations representing about 23 sites contribute data, in addition to Community Health Centre and Community Care Access Centre data from the HNHB LHIN as well as Cambridge Hospital in WW LHIN. In the next year, additional WW LHIN hospitals are considering leveraging IDS.

There are over 200 registered users (primarily analysts). Integrating data from IDS into ClinicalConnect is being considered since it can provide valuable complementary information to physicians at the point of care and to assist emergency room providers.

eHealth Ontario Projects

HNHB LHIN was very successful in receiving provincial eHealth Ontario funding to assist with a number of projects. This will help the LHIN advance its local strategic plan, aligned with government priorities. The LHIN is central to many projects and continues to work with other LHIN partners in Southwestern Ontario, eHealth Ontario and Canada Health Infoway. Examples of projects supported through funding from eHealth Ontario through the HNHB LHIN include:

- e-Physician provided funding to integrate hospital data to ClinicalConnect to increase the value among front-line providers
- ALC Resource Matching and Referral is improving the process and efficiency of referring acute patients to other levels of care with further phases now being planned.
- Connect Southwestern Ontario (cSWO) – a proposal to create a collaborate cluster to further "Connect South Western Ontario" in eHealth related activities
- Diagnostic Imaging Repository shared amongst four LHINs in the cSWO cluster: HNHB, WW, SW and ESC

- CCIM – Community Care Information Management Repository for Mental Health and Addictions information.

Much of the success in obtaining funding for this work arises from the LHIN's interest in working with other LHIN partners. By building partnerships and coordinating resources, the four LHINs in southwestern Ontario (Erie St. Clair, Waterloo Wellington, South West and HNHB) are working toward building an efficient and effective e-health system for the residents of our communities.

Emergency Room Wait Times

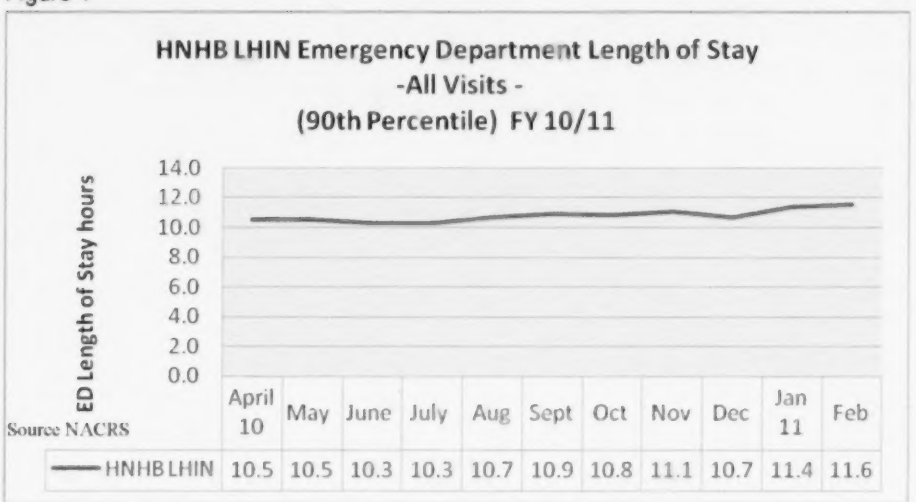
Improving timely access to emergency room (ER) services continued to be a priority for the HNHB LHIN in 2010-11. During the year, LHIN hospitals reported an increase in the number of ER visits, and an increase in the number of seniors with complex conditions seen in the ER, which impacted the overall length of stay (LOS). Strategies to reduce wait times in the emergency room focused on reducing ER demand, improving efficiencies in the ER, and improving in-patient hospital flow.

The LHIN's overall ER LOS for patients remained stable until December 2010, when wait times started to increase (refer to Figure 1). The increase in overall ER LOS can be attributed to the increased wait time experienced by individuals waiting in the ER for an in-patient bed (Figure 2).

Factors identified by LHIN hospitals impacting the admitted patient wait time include

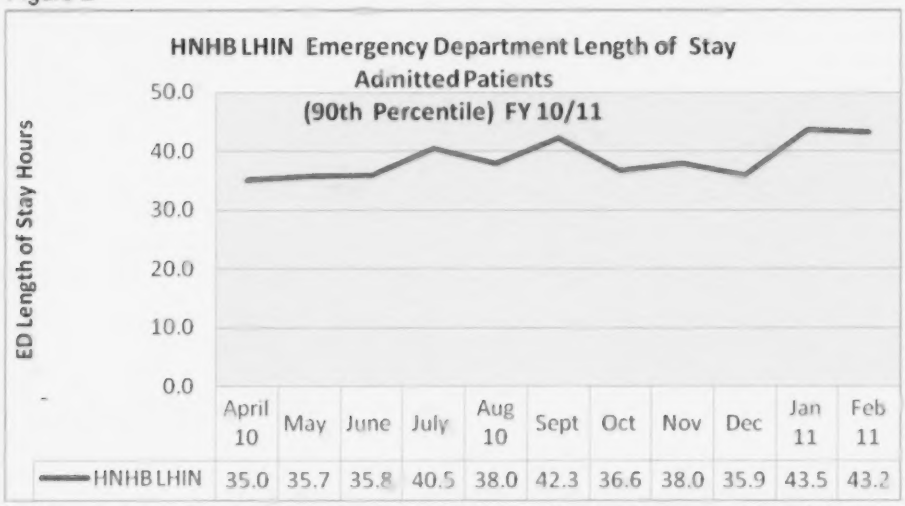
- Increase in the number of ER visits
- Increase in the number of seniors with more complex conditions presenting to the ER
- A higher number of individuals requiring isolation
- Availability of inpatient beds
- Number of LHIN long-term care homes with admission restrictions due to outbreaks, such as influenza

Figure 1



(Source: CCO-ATC -Public Reporting and Pay-for-Results Hospital Comparison Report Feb 2011).

Figure 2



(Source: CCO-ATC -Public Reporting and Pay-for-Results Hospital Comparison Report Feb 2011).

Key Activities to Reduce ER Demand and ER Wait Times

Pay for Results (P4R)

In 2010-11, the number of HNHB LHIN ERs participating in the Ministry of Health and Long-Term Care's Pay-for-Results (P4R) initiative increased from seven to eight, with the addition of the Niagara Health System, Greater Niagara General Site. Through this strategy, hospitals focused on reducing the time people spend waiting in the emergency room by implementing initiatives to streamline patient flow. These initiatives included *Rapid Assessment Zones* for low acuity patients, Patient Flow Coordinators, enhancing ER support services, additional Triage Nursing time, additional ER Physician hours, and operating 'Express Units' that provide temporary in-patient capacity while patients are waiting to be discharged.

Participating HNHB LHIN Hospitals:

- Hamilton Health Sciences
  - Hamilton General Hospital
  - Juravinski Hospital and Cancer Centre
  - McMaster Children's Hospital
- Brant Community Healthcare System
- Niagara Health System
  - St. Catharines General Hospital
  - Greater Niagara General Hospital
- Joseph Brant Memorial Hospital
- St. Joseph's Healthcare Hamilton

As of February 2011:

- Seven LHIN P4R sites have been challenged to increase the proportion of **admitted patients** treated within the recommended wait time. This is in contrast to last year when all P4R sites reported improvement. However, as of December 2010, the number of hours residents spent in the ER waiting to be admitted to a hospital bed decreased by 8.3 over April 2008.
- Six HNHB LHIN P4R sites showed an increase in the proportion of non-admitted high acuity patients treated within the recommended wait time, and six of the eight sites achieved 90% or greater

performance in this measure, meeting the ministry set target. For low acuity patients, although the overall wait time remained relatively constant, seven of eight P4R sites have improved over their baseline measure.

Emergency Department Performance Improvement Program (ED PIP)

In 2010-11 two LHIN P4R sites participated in the Ministry's Emergency Department Process Improvement Program (ED-PIP). With the addition of these sites, all LHIN P4R sites will have completed the ED-PIP initiative. This program applies LEAN methodology to hospital-wide patient flow processes by engaging multiple hospital departments focused on emergency room wait time improvement. ED PIP strategies focused on emergency room triage processes, streamlining patients by level of illness, improving processes for laboratory and diagnostic image testing, and improved discharge processes for in-patients to make room for the newly admitted ER patients.

Health Care Connect

This program, operated by the HNHB Community Care Access Centre (CCAC), connects people without a family physician to primary care. Since the program's inception in February 2009, the HNHB CCAC has made 3,761 matches across the HNHB LHIN. As of February 28, 2011, 116 physicians were participating in the program.

Increased Access to Urgent Care Centres (UCC)

Residents with non-emergent health care needs can be treated at urgent care centres quicker than emergency rooms. The LHIN's sixth UCC opened April 2011 as part of the Hamilton Health Sciences Access to Best Care initiative. In 2010-11, two LHIN urgent care centres reported an overall maximum wait time for nine out of ten individuals of approximately three hours compared to the LHIN overall wait time of 11 hours.

Internal Medicine Rapid Access (IMRA)

In 2010-11 two Internal Medicine Rapid Assessment Clinics opened at Hamilton Health Sciences, General Site and St. Joseph's Healthcare Hamilton. These clinics funded through the LHIN's Aging at Home strategy facilitates access to General Internal Medicine (GIM) Consultations through an out-patient clinic. The program reduces ER wait-times by providing access to General Internal Medicine Physicians within a 24-48 hour period of time, thereby allowing ER physicians to safely discharge patients that can be seen on an out-patient basis rather than waiting in the ER.

In December 2010, both programs reported a 69% reduction in ER wait times for patients seen in the clinic that required a GIM consult compared to those who were seen in the ER for a GIM consult. This program also facilitates faster discharge for patients admitted to a General Internal Medicine bed. Physicians are discharging appropriate patients home sooner when they can be seen for follow up in the clinic within 24-48 hours.

Expansion of Nurse Practitioners in Long-Term Care Homes

This program allows residents to be treated in their long-term care homes, avoiding transfers to the emergency room or hospital which can be stressful for residents and their families. As of December 2010, 4,154 LHIN long-term care home residents were cared for by nurse practitioners. Based on those visits, it is estimated that 1,630 transfers from long-term care to emergency were avoided. Of the 4,154 long-term care home residents that were assessed by the nurse practitioner, less than 1% required a hospital transfer. The Nurse Practitioner Long-Term Care Home team also provided 134 education sessions to build clinical capacity within the LHIN's long-term care home sector.

Community Care Access Centre (CCAC) Case Managers

As of February 2011, 3,711 emergency room admissions were potentially avoided as a result of CCAC case managers being located in emergency rooms. When appropriate, CCAC case managers can arrange for care to be provided in the community rather than in hospital.

Emergency Services Steering Committee

The HNHB LHIN's Emergency Services Steering Committee (ESSC) provides leadership to HNHB LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services within the HNHB LHIN community.

In 2010-11, the ESSC:

- Approved one-time funding to support:
    - the Community Referral by Emergency Medical Services (EMS) (CREMS) project in Hamilton.
    - an ER Diversion pilot project by the Niagara EMS "OMEGA" project.
- Monitored and advised on ER Pay-for-Results sites.
- Participates on the steering committee of the SMART- AMI project – a LHIN-wide best practice project to treat an "ST Elevated" heart attack.
- Commissioned a report specific to the HNHB LHIN on the use of medical directives in LHIN Hospital ERs, with a vision to standardize medical directives best practices across the LHIN.
- Worked collaboratively with the Central South Infection Control Network to progress infection control practices within the LHIN. An HNHB LHIN infection control forum will be held in May 2011.

Patient Flow

In 2010-11, the HNHB LHIN's Patient Flow Strategy (PFS) focused on facilitating the transition of people to the most appropriate care setting after acute hospital care is complete. This strategy had three overarching goals:

- Improve access to post acute care settings that provide people with the level of care that optimizes their health status and health outcomes.

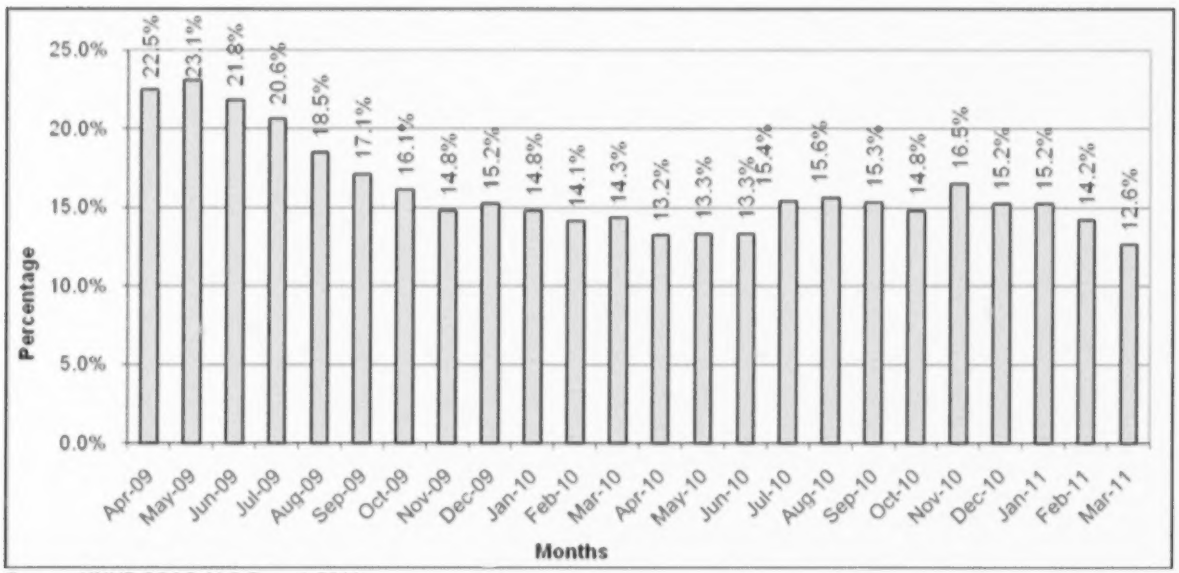
- Improve access to inpatient services by improving patient flow from hospital back to the community.
- Strengthen and increase community services to support people to be able to return and live safely at home.

One of the metrics used by the LHIN to measure the number of days a person waits in hospital for an alternate level of care (ALC) is the acute ALC rate. A low rate means that people spend less time waiting in an acute hospital for post acute care. The post acute care setting people wait for depends on their immediate and long-term care needs and include: post acute restorative/convalescent care, complex care, rehabilitation services, home with community support services, mental health services, assisted living/supportive housing and long-term care home.

In 2009-10, the LHIN demonstrated a substantial decrease in the LHIN's ALC rate from 22.5% in April 2009 to 14.3% in March 2010. This means that people waited less time to be able to transition to a post acute care setting. During 2010-11 the LHIN's ALC rate remained relatively constant at 14-15% until March 2011 when it decreased to 12.6%.

The LHIN's success over the past year is demonstrated by:

- sustaining the gains made in the ALC rate
- reducing the number of people experiencing long waits for long-term care or other alternate care settings; and
- the high percent of individuals discharged home from the LHIN's Assess Restore (restorative) programs.

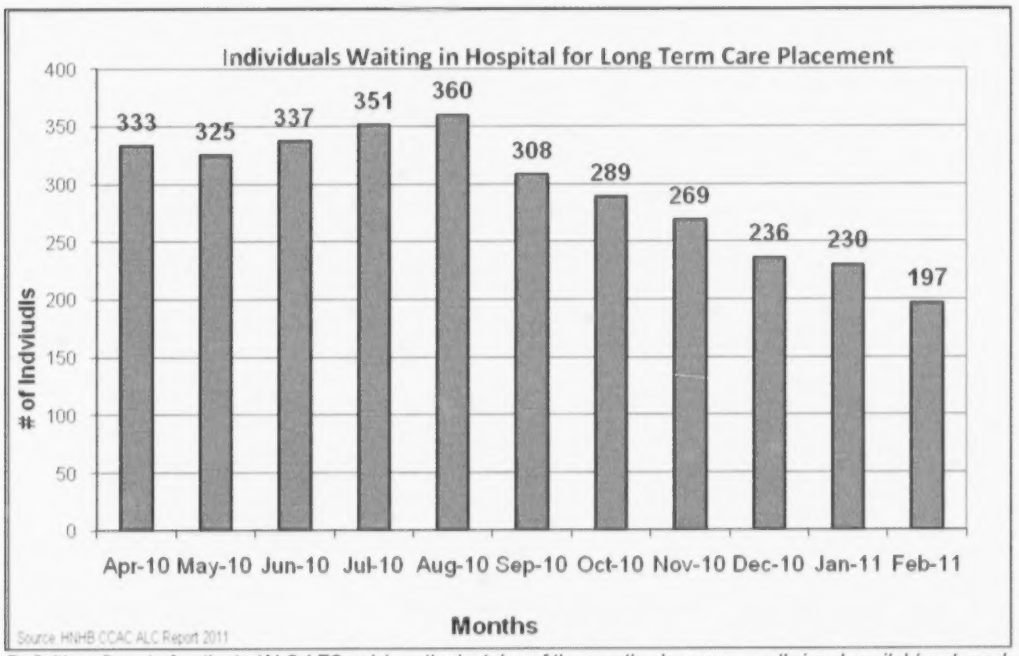


Source: HNHB CCAC ALC Report, 2011.

The LHIN works closely with its health service providers, the LHIN Alternate Level of Care Steering Committee and the HNHB LHIN Community Care Access Centre to identify strategies to improve patient flow.

Key Activities to Improve Patient Flow:

- In 2010-11, LHIN partners worked together to facilitate the transition of over 500 people who were experiencing long waits in hospital for discharge to a long-term care home.



Definition: Count of patients (ALC-LTC only) on the last day of the month who are currently in a hospital (acute and other inpatient beds) and who are on a waitlist for a long-stay LTCH bed.

- Continuation of the LHIN restorative in-patient care beds, increasing to 118 beds across the LHIN in 2010-11. The restorative units were established to provide an area where seniors that are medically stable can receive slower paced restorative care to prepare them to transition back home. Most importantly, the program continues to strive to put our seniors first by providing an opportunity to optimize both their functional and cognitive ability to be able to return home where life changing decisions can best be made. In the first six months of 2010-11, the programs report that 77% of individuals admitted in these restorative beds were discharged home. This equates to 355 individuals.

- HNHB LHIN hospitals and the HNHB CCAC continued to work collaboratively with individuals and their families to support their ability to return individuals home from hospital or avoid their admission to hospital by providing additional supports in the home. Timely return home from hospital avoids complications that can occur with long and unnecessary hospital stays.

- Three LHIN long-term care homes provide specialized care for individuals requiring chronic kidney peritoneal dialysis.

- Continued support of 17 interim long-term care beds across the LHIN.

Accountability and Performance

The HNHB LHIN posts a balanced scorecard on its website and updates it quarterly.

The scorecard provides a snapshot on the performance of the local health system using select performance measures across four domains:

- System integration
- Client access and outcomes
- Financial and sustainability
- Organizational health

Wait Times Strategy

The HNHB LHIN's 2010-11 Ministry-LHIN Performance Agreement (MLPA) indicators can be grouped into two categories that report on:

- people's access to:
    - four elective surgery and two diagnostic services
    - post acute care services after acute treatment is completed
    - timely emergency room services
- the number of times people return to hospital within an identified length of time for select medical conditions.

In 2010-11, the LHIN built on the successful collaboration established with HNHB Community Care Access Centre, the LHIN's Wait Time Advisory Committee (and subcommittee work groups), Emergency Services Steering Committee, Alternate Level of Care Steering Committee, Chronic Disease Prevention and Management Committee and, LHIN providers with expertise for mental health and addictions services. Together, these stakeholders work toward improving access to timely and quality health services for LHIN residents.

Performance: Selected Surgery and Diagnostic Services

This narrative provides a brief overview of the 2010-11 MLPA performance indicators for the HNHB LHIN (refer to table on page 41).

In 2010-11 the LHIN achieved wait time reductions for elective cardiac by-pass surgery and CT diagnostic scans over the initial starting point. Services where wait times did not improve include: Cancer surgery, Cataract, Hip and Knee Replacement surgery and MRI scans.

To improve wait times in 2010-11 the LHIN, together with its hospitals, undertook the following activities:

- Select LHIN hospitals participated in provincial program improvement planning for increased efficiencies in Magnetic Resonance Imaging (MRI)
- Participated in the provincial 'MRI Priority 4 Initiative' to reduce MRI scan wait times for elective scans
- Established a LHIN-wide Diagnostic Imaging Quality Council
- Reviewed and initiated processes to better streamline surgical wait list practices
- Increased operating room time for surgeons with longer wait times

- Completed four in-year reallocations of wait time resources. This allowed the movement of wait time volumes between LHIN hospitals to meet the demand while optimizing available hospital capacity.
- Implemented hospital specific action plans to reduce wait times for key services
- Expansion of the Regional Joint Assessment Program to Niagara Health System

While the LHIN did not see a reduction in wait times for total hip and knee replacement or cataract surgery, the LHIN worked specifically with hospitals to address a number of long wait cases existing on surgeon wait lists for these services. Volumes were reallocated to the hospitals and hospitals increased operating room time for surgeons to complete cases with long wait times.

Though this strategy did not reduce reported wait times, (which are calculated as the time individuals wait when the case is completed) it did focus on the needs of the individuals who were experiencing long waits for these services.

Challenges that limited wait time reduction included:

- Higher wait times reported for specific cancer services (increased demand or minimal invasive procedures)
- Higher demand for emergency room services
- Surgery cancellations due to availability of an inpatient bed as a result of unplanned increases in hospital demand or inability to discharge an individual to post acute level of care
- Increased demand for CT and MRI services

HNHB LHIN Ministry-LHIN Performance Agreement (MLPA): Performance Indicators 2010-11

Performance Indicator	HNHB LHIN 10/11 Starting Point	HNHB LHIN 10/11 Target	Most Recent Quarter Q4 2010/11	Fiscal Year Results	HNHB LHIN Met Target? Yes/No
1. 90th Percentile Wait Times for Cancer Surgery	**58 days**	**58 days**	**65 days**	**61 days**	**No**
• The HNHB LHIN exceeded its volumes in cancer surgery by 4%. Both Hamilton Health Sciences (HHS) and St. Josephs Healthcare Hamilton (SJHH) ended the year slightly above the year end target. HNHB continues to maximize operating room (OR) time by scheduling Cancer Surgery into cancelled OR times • Demand has grown in both Prostrate and Thyroid surgeries and wait times are affected. Both Prostrate and Thyroid cancer surgeries have the highest wait times in the LHIN but are below provincial wait times. Demand for prostate surgery is especially high at SJHH for the minimally invasive technique used there. • SJHH successfully recruited two Thoracic surgeons in November 2010, which has contributed to reduced wait times at year end. • Successful recruitment of orthopedic oncologist at HHS is expected to reduce wait times in 2011-12. • Consolidation of cancer surgeries for specific cancers is expected to result in increased efficiencies in 2011-12. • A new Cancer Surgery Wait Time Management Committee has been formed in the LHIN to monitor wait times and uptake of best practice guidelines.					
2. 90th Percentile Wait Times for Cardiac By-Pass Procedures	**48 days**	**48 days**	**43 days**	**34 days**	**Yes**
• The LHIN's wait times for elective cardiac bypass surgery are below the LHIN target of 48 days. • The LHIN has worked closely with the MOHLTC provincial services to increase the LHIN's allocation for cardiac surgery services which resulted in an increased allocation for both 2009-10 and 2010-11. • The LHIN's cardiac surgery services are provided by one hospital, HHS, one of the provinces 11 provincial cardiac surgery centres. HHS has reported growth in cardiac surgery over the last three years, 2% in 2009-10 and is projecting to complete a record high 1,620 cardiac surgery cases in 2010-11; a 3% growth over 2009-10. • The LHIN and its cardiac working group continues to monitor cardiac surgery services closely.					
3. 90th Percentile Wait Times for Cataract Surgery	**104 days**	**104 days**	**129 days**	**127 days**	**No**
• LHIN hospitals took a collaborative approach by reviewing volumes and reallocating resources throughout the year. • Niagara Health System and Joseph Brant Memorial Hospital (JBMH) were provided additional volumes transferred within the LHIN in Q4 to be used specifically on long wait cases. • JBMH reduced wait time from 176 days in January 2011 to 148 days in March 2011.					

- The LHIN reduced overall Cataract wait times in Q4 from 158 days in January 2011to 125 days in March 2011.
- Niagara is moving towards ophthalmologic procedures being performed at the Welland Site as a Center of Excellence in August 2011. A central intake process is in the preliminary discussion phase.
- The LHIN anticipates that 2011-12 reporting will show evidence of reduced wait times by closely monitoring each hospital's wait times and addressing long wait cases with in-year re-allocations in each quarter.

4. 90th Percentile Wait Times for Hip Replacement	**177 days**	**177 days**	**216 days**	**201 days**	**No**
5. 90th Percentile Wait Times for Knee Replacement	**209 days**	**182 days**	**231 days**	**217 days**	**No**

- Increased utilization of Regional Joint Assessment Program with the expansion to Niagara Health System in October 2010.
- Data quality review and subsequent re-education regarding data submission for surgeon offices at Niagara Health System resulted in data corrections as well as identification of long wait cases.
- Availability of beds has resulted in a number of cancelled Total Joint Replacement (TJR) surgeries which may impact wait times.
- A collaborative approach between LHIN hospitals by reviewing volumes and reallocating volumes more frequently to address high wait times. This may impact the LHIN's wait times in the first quarter of 2010-11.
- LHIN hospitals continue to work with their orthopedic surgeons offices to improve the quality of wait time data.
- The LHIN continues to meet monthly with those hospitals that report higher wait times.
- 2011-12 Wait Time Strategy allocations will be closely monitored by the LHIN and high wait times will be address with in-year re-allocations amongst hospitals.

6. 90th Percentile Wait Times for Diagnostic MRI Scan	**100 days**	**95 days**	**117 days**	**119 days**	**No**

- SJHH completed provincial MRI Process Improvement Program (PIP) in May 2011. The implementation of process improvement initiatives are targeted to improve performance/process metrics, to decrease wait-times, increase access and improve capacity.
- JBMH extended operating hours during the year to address greater demand as well as accommodate additional MRI Blitz funded volumes.
- JBMH will be participating in the MRI-PIP project sponsored by the MOHLTC which will include a review of the current protocol and booking process in both MRI and CT to ensure optimal use of resources and scheduling opportunities.
- Development of an HNHB DI Quality Council will provide a forum and process to develop and implement coordinated strategies and tactics to improve access, wait times and quality improvements as it relates to the provision of diagnostic services across the HNHB LHIN.
- Five HNHB hospitals participated in an MRI Blitz to help reduce the backlog of Priority Level 4 MRI (elective) scans. By March 31, 2011, four hospitals reported a reduced wait time on average of 57 days. One hospital experienced an increase in wait times as a result of increased demand.
- A new MRI was approved for HHS in 2011-12. HHS will expand hours until the new MRI is operational.
- In 2010-11 MRI wait times increased at HHS due to planned slowdown to facilitate relocation of

equipment and services into new imaging department in August. Post move required significant staff orientation to new work environment and training on new equipment. • Brant Community Healthcare System (BCHS) was able to significantly reduce the MRI wait time with the additional funded hours for 2010-11.					
7. 90th Percentile Wait Times for Diagnostic CT Scan	**49 days**	**43 days**	**46 days**	**43 days**	**Yes**
• The LHIN met its target for CT scans in 2010-11. • Implementation of city-wide centralized booking/call centre in Greater Hamilton area. • JBMH increased hours of operation to six hours per day Monday to Friday (07:00-23:00hr), to address wait times. • Niagara Health System (NHS) continues to equalize work across its three CT sites in an effort to keep wait times as low as possible. • BCHS maintained the wait time for CT while experiencing interruptions to service during the CT upgrade and construction project. With the construction complete and the new system installed and wait time hours increased, it is expected that the CT wait time will decrease of the first quarter of 2011-12.					
8. Percentage of Alternative Level of Care (ALC) Days – By LHIN of Institution	**20.97%**	**11.00%**	**17.82%**	**17.88%**	**No**
• The HNHB LHIN has seen an improvement in the percentage of ALC days from the starting point of 20.97% to the most recent 17.88%. The improvement from 20.97% to a reported 14.9% in July 2010 can be attributed to a continued focus on the Home First philosophy and restorative programs such as Assess & Restore, where 81% of patients admitted to the program are discharged home. • The ALC rate peaked in September 2010 at 21.7% as a result of a focused strategy to place over 300 individuals with long waits for long-term care (ALC-LTC), some with waits greater than 1,500 days. The impact of this strategy prevented the HNHB LHIN from achieving the 11% ALC target, but facilitated the transition of all but 10 individuals identified on the July 2010 Cancer Care Ontario (CCO) long stay survey to the right level of care. • In 2011-12, the LHIN and the ALC Steering Committee plan to work on a number of strategies to reduce the ALC rate. These include: Home First philosophy, maximizing restorative programs, completing intensive case reviews on any patient ALC for > 30 days, and early identification of frail seniors in the community, in the ER, and upon admission to hospital to ensure timely access to community services to support individuals ability to live at home. • The LHIN's internal monitored ALC rate was 12.6% as of March 31, 2011.					
9. 90th Percentile ER Length of Stay (LOS) for Admitted Patients	**35.5**	**28.3**	**42.12**	**38.92**	**No**
• Admitted ER Length of Stay has been the most challenging of ER metrics to improve. ER LOS is reflective of admitted patient flow within the hospital. • Between January and March 2011, hospitals (and the province) saw a spike in the overall ER LOS, and Admitted ER LOS, (particularly in January). This increase of approximately 7 hours did not return to pre-January levels (December 35.9 vs. January 43.5). • The patient flow challenges within the hospital that have contributed to an increase in ER LOS for admitted patients over the fiscal year 2010-11 are: availability of acute care beds, high numbers of					

admitted patients in the ER, infection control protocols, increasing high acuity and more complex cases with co-morbidities, an increase in the number of presentations of influenza, increased numbers of outbreaks in long-term care homes in the community, and decreased access to services over the holiday season/breaks.

- The LHIN meets monthly with hospitals with longer ER wait times to discuss strategies to improve performance.
- In the next fiscal year the LHIN will have increased temporary acute care bed capacity with 24 short stay beds across three hospital sites.

10. 90th Percentile ER LOS for Non-Admitted Complex (CTAS I-III) Patients	**8.1**	**7.5**	**7.77**	**7.87**	**No**

- While the LHIN improved its performance over its starting point for this indicator, it finished the year with 0.37 hours negative variance from the LHIN target which represents a 5% variance.
- There is a two year trend of increasing High Acuity Patient volumes. From January to March 2011, the LHIN's ERs treated 2,000 more high acuity cases representing a 3% increase over the preceding three month period Q3 2010-11.
- Despite the continued increasing volume trend, the overall LHIN ER LOS improved in this patient group.
- West Lincoln Memorial Hospital (WLMH), which has the highest ER LOS for this group, has entered into planning agreements with a partnering hospital to improve access to Diagnostic Imaging Resources. In 2011-12 the hospital has also implemented an electronic bed board monitoring system.

11. 90th Percentile ER LOS for Non-Admitted Minor Uncomplicated (CTAS IV & V) Patients	**5.1**	**4.5**	**4.95**	**4.82**	**No**

- The LHIN year end for this indicator was 0.32 hours from target or a 7% negative variance. The LHIN remains 0.5 hours from the provincial performance at year end.
- Across the LHIN ER LOS for this group range from 2.0 to 6.9 hours in for the period January to March 2011.
- Non-Admitted patient groups are impacted by the Admitted patients in the ER waiting for a bed, as there are a fixed number of ED stretchers.
- LHIN hospitals have implemented Rapid Assessment Zones, Medical Directives, Physician See and Treat areas, and Nurse Practitioners to improve the flow of the non-admitted low acuity patient group.

12. Repeat Unplanned Emergency Visits within 30 Days for Mental Health Patients	**17.1%**	**15.4%**	**15.98%**	**16.95%**	**No**

- Although the LHIN did not achieve year end target in this metric, it has seen an overall improvement with a continued downward trend towards target.
- The LHIN completed chart audits of frequent users of the ER with mental health and addictions – this led to an intensive case management review approach by the LHIN.
- Themes, recommendations and opportunities are emerging to inform our future planning around this indicator.
- COAST model has been funded in Niagara which will likely have a positive impact on this indicator.
- Key LHIN investments targeted at reducing repeat unplanned emergency visits for the mental health

population include: Expansion of Special Geriatric Services in Niagara and Haldimand Norfolk, crisis intervention, and sessional fees to increase access to psychiatrists in underserviced areas in our LHIN (Haldimand Norfolk, Brant, Niagara and Burlington). • OCAN (Ontario Common Assessment of Need) implementation in the mental health sector to facilitate right service at the right time.					
13. Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Patients	**19%**	**17.1%**	**20.34%**	**21.43%**	**No**
• There is a high proportion of individuals with concurrent disorders (substance abuse and mental health issues). Health service providers have identified this population as challenging to serve. • The LHIN did not achieve its year end target in this metric and actually had an increase from the target. • Key LHIN investments targeted to reduce repeat unplanned emergency visits for this population include: crisis intervention and transitional housing/beds for mental health/substance abuse, homeless and persons with chronic alcoholism (in partnership with City of Hamilton and Shelter Health Network), and the COAST model funded in Niagara.					
14. Readmission within 30 days for Selected CMGs	**15.1%**	**14%**	**15.03%**	**15.10%**	**No**
• The LHIN did not meet the year end target in this metric, however, the last quarter shows that the metric is trending down. • The LHIN is engaging its Chronic Disease Prevention and Management Advisory Committee to provide advice for developing a targeted strategy to decrease readmissions for these select CMGs. • The LHIN is working with key stakeholders to examine the reasons behind the readmits for the seven CMGs. • The LHIN is in communication with Health Quality Ontario to prepare for adoption of forthcoming recommendations from the provincial advisory panel on avoidable hospitalizations.					

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2011

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2011

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of financial activities 4

Statement of changes in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-15

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2011, and the statements of financial activities, changes in debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Membre de / Member of Deloitte Touche Tohmatsu

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2011 and the results of its financial activities, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

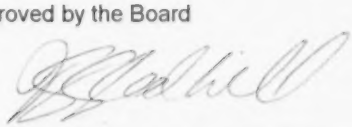
Chartered Accountants
Licensed Public Accountants
May 31, 2011

Hamilton Niagara Haldimand Brant Local Health Integration Network

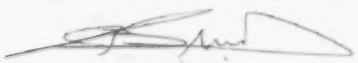
Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**1,869,146**	546,544
Accounts receivable - Ministry of Health and Long-Term Care ("MOHLTC")	**-**	35,000
HST receivable	**49,796**	-
Accounts receivable - other	**-**	6,634
Due from MOHLTC to Health Service Providers ("HSPs") (Note 9)	**11,338,713**	1,374,800
Due from the LHIN Shared Services Office (Note 4)	**-**	4,968
	13,257,655	1,967,946
Liabilities		
Accounts payable and accrued liabilities	**1,077,030**	555,276
Due to the MOHLTC (Note 3b)	**851,197**	54,863
Due to HSPs from MOHLTC (Note 9)	**11,338,713**	1,374,800
Due to the LHIN Shared Services Office (Note 4)	**4,089**	-
Deferred capital contributions (Note 5)	**311,967**	481,618
	13,582,996	2,466,557
Commitments (Note 6)		
Net debt	**(325,341)**	(498,611)
Non-financial assets		
Prepaid expenses	**13,374**	16,993
Capital assets (Note 7)	**311,967**	481,618
Accumulated surplus	**-**	-

Approved by the Board



Juanita G. Gledhill, Board Chair



Jack Brewer, Vice Chair

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (Unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**2,440,495,590**	**2,600,261,574**	2,493,218,669
Operations of LHIN	**5,105,872**	**5,174,872**	5,096,546
E-Health (Note 10a)	**600,000**	**600,000**	600,000
E-Health-Physician Demonstration Project (Note 10a)	-	**200,000**	-
Residents First (Note 10b)	-	**498,500**	209,750
ER/ALC Performance Lead (Note 10c)	-	**100,000**	100,000
French Language Services (Note 10d)	-	**74,670**	78,000
French Language Planning Entity (Note 10d)	-	**152,924**	-
Emergency Dept LHIN LEAD (Note 10e)	-	**75,000**	75,000
Critical Care LHIN LEAD (Note 10f)	-	**75,000**	-
Aboriginal Planning (Note 10g)	**37,500**	**37,500**	37,500
Diabetes Self Management	-	-	35,000
Diabetes Strategy	-	-	25,000
Amortization of deferred capital contributions (Note 5)	-	**185,756**	229,600
	2,446,238,962	**2,607,435,796**	2,499,705,065
Expenses			
Transfer payments to HSPs (Note 9)	**2,440,495,590**	**2,600,261,574**	2,493,218,669
General and administrative (Note 11)	**5,105,872**	**4,863,116**	5,319,297
E-Health (Note 10a)	**600,000**	**600,000**	600,000
E-Health-Physician Demonstration Project (Note 10a)	-	**200,000**	-
Residents First (Note 10b)	-	**162,855**	161,736
ER/ALC Performance Lead (Note 10c)	-	**100,000**	100,000
French Language Services (Note 10d)	-	**60,516**	78,000
French Language Planning Entity (Note 10d)	-	**152,924**	-
Emergency Dept LHIN LEAD (Note 10e)	-	**74,364**	75,000
Critical Care LHIN LEAD (Note 10f)	-	**72,167**	-
Aboriginal Planning (Note 10g)	**37,500**	**37,083**	37,500
Diabetes Self Management	-	-	35,000
Diabetes Strategy	-	-	25,000
	2,446,238,962	**2,606,584,599**	2,499,650,202
Annual surplus before funding repayable to the MOHLTC	-	**851,197**	54,863
Funding repayable to the MOHLTC (Note 3a)	-	**(851,197)**	(54,863)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	Budget (Unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Annual surplus	-	-	-
Change in other non-financial assets	-	3,619	2,520
Acquisition of capital assets	-	(16,105)	(9,327)
Amortization of capital assets	-	185,756	229,600
Decrease in net debt	-	173,270	222,793
Opening net debt	-	(498,611)	(721,404)
Closing net debt	-	(325,341)	(498,611)

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2011

	2011	2010
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	**185,756**	229,600
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	**(185,756)**	(229,600)
	-	-
Changes in non-cash operating items		
Decrease (increase) in accounts receivable - other	**6,634**	(6,490)
Decrease in accounts receivable - MOHLTC	**35,000**	188,200
Increase in HST receivable	**(49,796)**	-
(Increase) decrease in due from MOHLTC to HSPs	**(9,963,913)**	3,184,349
Increase (decrease) in accounts payable and accrued liabilities	**521,754**	(407,645)
Increase in due to the MOHLTC	**796,334**	54,863
Increase (decrease) in due to HSPs from MOHLTC	**9,963,913**	(3,184,349)
Increase (decrease) in due to the LHIN Shared Services Office	**9,057**	(21,201)
Decrease in prepaid expenses	**3,619**	2,520
	1,322,602	(189,753)
Capital investment		
Acquisition of capital assets	**(16,105)**	(9,327)
Financing transaction		
Capital contributions received (Note 5)	**16,105**	9,327
Net change in cash	**1,322,602**	(189,753)
Cash, beginning of year	**546,544**	736,297
Cash, end of year	**1,869,146**	546,544

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2011

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital asset and impairment in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHTLC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

2. Significant accounting policies (continued)

Capital assets (continued)

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2011 Surplus	2010 Surplus
	$	$	$	$
Transfer payments to HSPs	2,600,261,574	2,600,261,574	-	-
LHIN operations	5,174,872	4,677,360	497,512	6,849
E-Health	600,000	600,000	-	-
E-Health-Physician Demonstration	200,000	200,000	-	-
Residents First	498,500	162,855	335,645	48,014
ER/ALC Performance Lead	100,000	100,000	-	-
French Language Planning Entity	152,924	152,924	-	-
Emergency Dept. LHIN LEAD	75,000	74,364	636	-
Critical Care LHIN LEAD	75,000	72,167	2,833	-
French Language Services	74,670	60,516	14,154	-
Aboriginal Planning	37,500	37,083	417	-
	2,607,250,040	2,606,398,843	851,197	54,863

3. Funding repayable to the MOHLTC (continued)

b) The amount due to the MOHLTC at March 31, 2011 is made up as follows:

	2011	2010
	$	$
Due to MOHLTC, beginning of year	**54,863**	-
Funding repayable related to current year activities to the MOHLTC (Note 3a)	**851,197**	54,863
Amount recovered by the MOHLTC during the year	**(54,863)**	-
Due to MOHLTC, end of year	**851,197**	54,863

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**481,618**	701,891
Capital contributions received during the year	**16,105**	9,327
Amortization for the year	**(185,756)**	(229,600)
Balance, end of year	**311,967**	481,618

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2012	160,875
2013	157,275
2014	163,313
2015	172,786
2016	172,786
Thereafter	245,716

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2011 Net book value	2010 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	471,438	390,825	80,613	121,226
Computer equipment	129,581	128,303	1,278	15,828
Leasehold improvements	572,444	342,368	230,076	344,564
	1,173,463	861,496	311,967	481,618

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of financial activities reflect the initial budget at April 1, 2010. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,600,261,574 is derived as follows:

	$
Initial budget	2,440,495,590
Adjustment due to announcements made during the year	159,765,984
Final budget	2,600,261,574

The final LHIN general and administrative budget of $6,995,966 is derived as follows:

	$
Initial budget	
LHIN operations	5,105,872
E-Health	600,000
Aboriginal Planning	37,500
Additional funding received during the year for	
Stabilization increase	76,500
Residents First	498,500
E-Health-Physician Demonstration Project	200,000
French Language Planning Entity	152,924
ER/ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
French Language Services Coordinator	74,670
Final budget	6,995,966

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,600,261,574 (2010 - $2,493,218,669) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2011 as follows:

	2011	2010
	$	$
Operation of hospitals	**1,781,194,426**	1,718,425,416
Capital contributions - Health Infrastructure Renewal Fund	**5,119,191**	5,417,098
Grants to compensate for municipal taxation - public hospitals	**458,100**	462,075
Long term care homes	**411,353,925**	396,752,189
Community care access centres	**248,141,094**	228,780,891
Community support services	**41,210,576**	39,376,097
Acquired brain injury	**6,429,869**	6,086,497
Assisted living services in supportive housing	**24,178,932**	24,345,509
Community health centres	**20,909,757**	16,255,575
Community mental health addictions program	**61,265,704**	57,317,322
	2,600,261,574	2,493,218,669

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As at March 31, 2011 an amount of $11,338,713 was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's financial activities and is included above.

10. *a) E-Health*

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $800,000 (2010 - $600,000). $600,000 of these funds were used toward initiatives in support of the Project Management Office for 2011 update of the E-Health strategic plan and $200,000 were used for the Physician Demonstration Project.

b) Residents First

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding, on behalf of all the LHINs, in the amount of $498,500 (2010 - $209,750) for all Residents First initiatives throughout the province. Of the total, $30,991 was for Residents First initiatives in the Hamilton Niagara Haldimand Brant LHIN. As directed by the MOHLTC, these funds were used to support training of staff that would result in performance improvement in Long-Term Care homes and help to reduce pressures on the Emergency Departments. Residents First supports long-term care homes in Ontario in providing an environment for their residents that enhances their quality of life and facilitates comprehensive and lasting change by strengthening the long-term care sector's capacity for quality improvement.

c) ER/ALC Performance Lead

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $100,000 (2010 - $100,000). These funds were used to support the activities of the ER/ALC Coordinator.

d) French Language Services

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $227,594 (2010 - $78,000). $74,670 of these funds was used to support the French Language Services Coordinator role and $152,924 was included in the initial allocation for the French Language Planning Entity.

10. (continued)

e) Emergency Department LHIN LEAD

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2010 - $75,000). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

f) Critical Care LHIN LEAD

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2010 - $nil). These funds were used toward initiatives in support of Critical Care LHIN LEAD activities.

g) Aboriginal Planning

During fiscal 2011, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $37,500 (2010 - $37,500). These funds were used to support Aboriginal Planning activities.

	2011	2010
	$	$
Travel	**487**	101
Salaries and benefits	**32,349**	-
Consulting services	**-**	500
Meeting expenses	**4,247**	36,812
Supplies, other	**-**	87
	37,083	37,500

11. General and administrative expenses

The Statement of financial activities presents the expenses by function. The following classifies general and administrative expenses by object:

	2011	2010
	$	$
Salaries and benefits	**3,384,397**	3,248,887
Board Chair per diems	**60,725**	55,650
Directors' per diems	**62,550**	73,150
Board expenses	**24,383**	57,095
Travel	**46,389**	48,246
Consulting services	**47,968**	481,998
Community forums and communication	**51,717**	122,186
Supplies, equipment, maintenance, other	**248,715**	318,105
Occupancy costs	**341,021**	309,380
Amortization	**185,756**	229,600
Shared services	**409,495**	375,000
General and administrative expenses	**4,863,116**	5,319,297
E-Health	**600,000**	600,000
E-Health-Physician Demonstration Project	**200,000**	-
Residents First	**162,855**	161,736
ER/ALC Performance Lead	**100,000**	100,000
French Language Services	**60,516**	78,000
French Language Planning Entity	**152,924**	-
Emergency Dept. LHIN LEAD	**74,364**	75,000
Critical Care LHIN LEAD	**72,167**	-
Aboriginal Planning	**37,083**	37,500
Diabetes Strategy - Self Management	**-**	35,000
Diabetes Strategy	**-**	25,000
	6,323,025	6,431,533
Reconciliation to MOHLTC approved budget		
General and administrative and initiatives expenses	**6,323,025**	6,431,533
Less: amortization	**(185,756)**	(229,600)
Add: due to MOHLTC	**851,197**	54,863
Add: purchase of tangible capital assets	**16,105**	9,327
	7,004,571	6,266,123

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 30 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $245,987 (2010 - $210,063) for current service costs and is included as an expense in the Statement of financial activities. The last actuarial valuation was completed for the plan on December 31, 2010. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

Board Members

(as of March 31, 2011)

Juanita G. Gledhill
Chair

Jack Brewer
Vice Chair

Douglas Archibald
Board Member

Ruby Jacobs
Board Member

Bob Lawler
Board Member

William (Bill) McLean
Board Member

William (Bill) Millar
Board Member

Janice Mills
Board Member
(Term completed June 16, 2010)

Helen Mulligan
Board Member

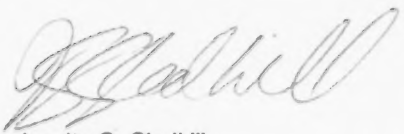
Michael Shea
Board Member

Senior Staff Members

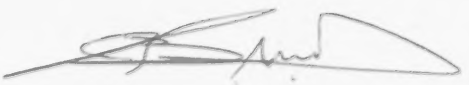
Donna Cripps
Chief Executive Officer

Alan Iskiw
Senior Director,
Performance, Contract and Allocation

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2011.



Juanita G. Gledhill
Chair, Board of Directors



Jack Brewer
Vice Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

LHIN Contact Information

Telephone:
905.945.4930
1.866.363.5446

Fax:
905.945.1992

Email:
hamiltonniagarahaldimandbrant@lhins.on.ca

Address:
264 Main Street East
Grimsby, ON L3M 1P8

Website:
www.hnhblhin.on.ca

YouTube
www.youtube.com/user/hnhblhin

twitter
@HNHB_LHINgage

ISSN 1911-2912
146 June/11

© 2011 Queen's Printer for Ontario

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé